Response to the Los Angeles County Board of Supervisors regarding possible creation of a health agency

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March 30, 2015

DRAFT REPORT

Message from the CEO

On January 13, 2015, the Board directed the Chief Executive Office, County Counsel and the Department of Human Resources, in conjunction with the Departments of Health Services, Public Health, and Mental Health to report back in 60 days on the benefits, drawbacks, proposed structure, implementation steps, and timeframe for the creation of a single unified health agency. This report is a draft of the response to this board motion.

From April 1 through May 15 there will be a 45-day public dialogue and comment period on this draft report. You may submit written comments to:

Office of Health Integration
Kenneth Hahn Hall of Administration
500 W. Temple Street, Room 726
Los Angeles, CA 90012
healthintegration@lacounty.gov

All written comments will be included as an appendix to the final version of this report. If you prefer your comments are not made public, please note that in your submission. During the 45-day comment period, public convenings will be conducted at different locations across the County. The dates and times of these events will be posted on the Health Integration website at http://priorities.lacounty.gov/health.

We look forward to receiving your comments and hope you can join us at a public convening. The final report will be submitted to the Board no later than June 30, 2015.

Sachi A. Hamai
Interim Chief Executive Officer

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Introduction

On January 13, 2015, the Los Angeles (LA) County Board of Supervisors unanimously approved in concept the creation of "a single, integrated agency" encompassing the Departments of Health Services, Mental Health, and Public Health[1], as well as the environmental toxicology bureau functions currently performed by the Agricultural Commissioner. The motion directed the Chief Executive Officer (CEO), County Counsel, and the Department of Human Resources (DHR), in conjunction with the Department of Health Services (DHS), the Department of Mental Health (DMH), the Department of Public Health (DPH), and Agricultural Commission to report back within 60 days on five issues: the benefits and drawbacks of the agency, proposed agency structure, possible implementation steps, and timeframe for achievement of the agency. The motion specifically requested a stakeholder/public participation process for soliciting broad input into the report. Finally, the motion was also amended to include consideration for moving the Sheriff Medical Services Bureau (MSB) into the agency as well. This document will address issues pertaining to the organizational integration of DHS, DMH, and DPH, collectively referred to at the Departments in this report. The possible transfers of MSB and the environmental toxicology lab are addressed in separate memos to the Board.

Each of the three County health Departments has a unique combination of policy, programmatic, regulatory, and direct care activities and strong organizational identities, assets, and constituent bases. Despite different areas of focus, important similarities exist, including mission-driven County staff, a wide and complex network of community partnerships, an ethic of service and cultural sensitivity, a commitment to evidence-based practices, and a focus on reducing health disparities among disadvantaged populations. More generally, all three share a goal of improving the health and well-being of LA County residents. In meeting this goal, the activities and responsibilities of the Departments are complementary.

There was a strong and convincing rationale behind the re-establishment of an independent Department of Mental Health in 1978 and the creation of an independent Department of Public Health in 2006 (see Appendix for additional detail on the history of the Departments). The moves allowed each to develop a strong identity and reputation in their fields, to prioritize their work to achieve their missions, and to avoid program budget cuts that could occur in the setting of financial deficits. Those supporting an integrated health agency do not discount the wisdom of these historical separations. Rather, they see service integration as imperative to, over the long term, improving services and programs, decreasing costs, reducing disparities, and improving health outcomes across LA County, particularly for those most disadvantaged, and see organizational integration at this point in time as the most effective pathway to service integration. In learning from the past, even the most ardent supporters of the integrated model advocate for maintaining separate budgets for the three Departments that could only be changed by the Board of Supervisors. Those hesitant about the creation of a health agency do not oppose care integration and its attendant benefits, but rather question whether the creation of a health agency is a necessary or even helpful step in the quest for better care outcomes.

The US health care system is moving toward integration. As examples, under the Affordable Care Act (ACA), California has placed responsibility for treating mild to moderate mental illness on the local health plans which provide health services and not in the specialty mental health system. Financial incentives place increasing focus on the role of the delivery system in achieving health care's triple aim[2], a goal that requires collaboration across all spheres. Section 1115 Medicaid Waiver renewal discussions focus on the importance of integrating physical and behavioral health and on the delivery system's role and responsibility in achieving population health goals. Managed care has increased reliance on capitated payment models in which providers are taking on more financial risk while also held to increasingly stringent standards for timely access and quality. This fact increases the need for delivery systems to effectively and cost-efficiently manage a population that

[1] Motion included in Appendix I.
[2] The health care triple aim: to improve overall health outcomes and population health; to improve quality and access and, as a result, experience of care; and to increase cost-effectiveness of care.

includes a large number of individuals with co-existing mental illness, substance abuse disorders, or multiple physical comorbidities. This is made more difficult when services and programs meant to benefit at-risk or vulnerable populations operate in isolation from one another.

A key agency role would be to lead and promote service integration where integration would benefit residents of Los Angeles. This does not imply that all facets of each Department would benefit from integration-related activities. Examples include certain health protection programs and regulatory functions within DPH, certain highly specialized tertiary care clinical services within DHS, and the public guardian role within DMH. Those areas that would not benefit should be left alone to develop independently. Similarly, creating an agency also does not mean that the Departments should limit their scope of activities or center all of their energy and resources on those areas where their treatment populations overlap. They should not. To be successful, each Department must maintain a vibrant, strong presence across its full scope and spectrum of services. While there is hope that an agency could yield long-term cost-savings, these savings will not come from service cuts, layoffs, or from narrowing the scope of activity of the three Departments.

The agency would focus on areas of opportunity, on those places where there is potential for synergy that is not currently being realized. It would not seek to fix what isn't broken within or between each Department. There are many individuals whose needs are fully met within the current system. Many individuals receive excellent care and many populations benefit from the activities of each Department. As stakeholders often stated: "please, leave it alone; it's working." For those who are well-served, an agency would not erode the quality of care provided. As regulatory and operational changes unfold across the broader health arena, the agency would need to ensure that each component of its systems of care is maintained and expanded to meet the needs of those served by the County.

There have been some successful examples of integration, what stakeholders highlighted as "pockets of success", but they also pointed to much larger areas where the system and its separate, largely siloed, efforts, are not effectively serving individuals and populations. "It's inefficient." "Confusing." "Broken." Individuals fall through the cracks and fail to get the services they need. Specific groups, often many of the most vulnerable populations within the County and including many that have been historically underserved, experience gaps in services and programs or remain entirely unserved. To address these gaps, the County must focus on building a radically transformed system that provides the highest quality health-related programs and services for all LA County residents and examine whether the creation of a health agency advances this goal.

Opportunities under a Health Agency

This section will highlight specific opportunities for integration between DHS, DMH, and DPH. Progress in these areas would yield significant benefit for those served by the County. While this section will focus on work that could be done to improve services to LA County's 10 million residents, it should not be taken as a denial that good work has already taken place within and between the three Departments. Still, numerous gaps remain.

This report will provide an overview of the major opportunities under an agency and examples of specific projects that could be pursued within each area. It will also offer examples of barriers that have held up progress to date, but will not specify an implementation plan for achieving each goal. This is the work that would be done, by necessity, over time.

The major rebuttal to the opportunities presented in this section is that it would be possible to achieve almost, if not all of the opportunities without transitioning to an agency and that non-agency solutions can equally achieve these shared objectives. Although most, if not all opportunities, could technically be achieved under any organizational structure, including under the current structure in which the Departments report separately to the CEO. Those critical of the agency model underscore this point and mention specific pockets of success as the evidence that an agency is not necessary to achieve service integration. However, those who support the agency model assert that without an agency leader setting the vision, priorities, and goals of integration and working through numerous operational challenges in reaching each goal, most will not be achieved. The County will continue to enjoy isolated achievements rather than building an organized and integrated health system. Opportunities that an agency might be well-positioned to capture are classified into the groups listed below.

1. Bridging population and personal health
2. Integrating services at the point of care for those seeking services in the County
3. Addressing major service gaps for vulnerable populations
4. Streamlining access to care
5. Using information technology, data, and information exchange to enable service integration
6. Improving use of space and facility planning to improve access and reduce costs
7. Improving ancillary and administrative services and functions
8. Maximizing revenue generation
9. Improving workforce education and training
10. Strengthening the County's influence on health policy issues
11. Aligning resources and programs to reduce health disparities

Bridging population and personal health

Initially integrated and highly collaborative, public health began to differentiate itself from clinical medicine in the early 20th century due in large part to the rise of the biomedical model of disease and a resulting devaluation of social determinants. Chronic underfunding and misaligned financial incentives also hurt in that payment structures rewarded treating disease rather than preventing it, paying for volume rather than value, and incentivizing specialty care and procedural interventions over primary and preventive care and health promotion activities. Despite this history, public health and primary care have complementary functions and share a common goal of improving a population's health, though the former defines "population" more broadly than the latter.

While the medicalization of physical health care was critical to progress in diagnosing and treating disease, the devaluation of social determinants of health during that same period was to the detriment of individuals and the achievement of

population health goals. When society began to again recognize the critical importance of social determinants in the late 20th century, it happened in the context of largely siloed public health and primary care expertise and infrastructure, limiting the feasibility of a coordinated and collaborative response. This is unfortunate. Most of the major challenges facing primary care providers involve factors that are not present in the clinic setting. According to a commonly cited statistic, only 10% of an individual's health is attributable to the care they receive, the remainder being determined by genetics, social circumstances, environmental exposure, and behavioral patterns.[3] Rising health care costs also underscore the importance of re-integration, given the important role of public health activities in achieving sustainable and cost-effective improvements in a population's health.

Public health and primary care integration efforts have shown to benefit individuals and populations. While DPH's activities should not be limited to those served within DMH and DHS, improved integration of primary care and public health could enhance the capacity of both Departments to carry out their respective missions by combining knowledge, resources, and skills, including leveraging DPH's strong ties at the community level to link those served in County facilities to community-based organizations and resources in areas such as prevention, health promotion, health education and management of chronic disease. Giving providers population-based information relevant to their practices could enhance their capacity to address behaviors and underlying causes of illness. At a very practical level, greater linkages could also ensure that individuals who screen positive to risk factors or disease in the community could have streamlined linkage to primary care, obstetric, or other appropriate clinical access points within a delivery system if they do not have an existing provider.

Without detracting from efforts with non-County based entities, DHS and DMH clinical environments could be rich sites to study, test and implement programs and tailor initiatives to better meet the needs of specific populations. Increased access to health information technology (IT) serves as a powerful tool in this regard. DPH could use the recent Electronic Health Record (EHR) implementations in DHS and DMH to monitor and learn about diseases or risk factors that cluster in low-income or vulnerable populations seen within the County, including but not limited to obesity, tobacco use, substance abuse, food security, prevention of prescription drug/opiate abuse, etc.

In a similar way, greater integration of public health and clinical service delivery can help to improve the County's ability to be nimble, timely, and effective in responding to public health threats. A few examples of how this may manifest include:

- Greater access to specialized services not available within public health (e.g., access to intravenous immunoglobulin during recent measles outbreak for exposed individuals)
- Enhanced ability to rapidly establish triage and screening stations and referral sites in case of an acute communicable disease threat
- Better understanding of the perspectives, experience, and capabilities of medical staff and thus ability to design training programs, protocols, and policies (e.g., design of partner-treatment protocols for STDs, development of policies regarding workforce training for Ebola)
- Greater ability to work with primary care providers on the importance of vaccination (e.g., measles) for low-income, at-risk populations

Integration efforts might also promote the seamless and strategic linkage of patients in the delivery system to community-based services. As one example, DHS and DPH are currently in year one of a four-year CDC-funded partnership to develop electronic tools that will be embedded in DHS' EHR to support DHS providers in identifying patients at risk for diabetes or hypertension, making decisions around how best to intervene in a way that mitigates a patient's risk, and linking patients to community-based services that are personalized to the patients' unique demographics and area of residence. As one stakeholder put it "the days where patients receive their health care within the walls of a clinic building or doctor's office

[3] Schroeder, S (2007). "We can do better – Improving the health of the American people." *NEJM, 357*(12), 1221-1228. Adapted from McGinnis, JM, et al, (2002). "The case for more active policy attention to health promotion." *Health Affairs, 21*(2), 78-93.

are over. The community is an important army for health care service delivery that needs a deeper tie into primary, specialty, mental health and other care." This point is more and more recognized in the personal health realm as evidenced by the evolution of the patient-centered medical home (PCMH) model. The most evolved PCMH models have seamlessly linked patients with community-based services (i.e., cooking courses, exercise opportunities, food and transportation access, health empowerment and self-efficacy programs, weight loss interventions, etc.), providing important connections that can address the root causes of disease.

Tighter integration between physical and public health also creates unique opportunities to strengthen programs that rely on both strong public health and clinic-based services. Needle exchange is one example. High rates of substance abuse threaten not just the health and well-being of those addicted, but also many who surround them. Needle and syringe exchange programs are one important mechanism for reducing the unnecessary spread of infectious diseases, with benefit for population health and a reduction in unnecessary utilization of costly health care services. Through closer integration, individuals being served in County operated or funded clinics that could benefit from needle exchange could be seamlessly connected with services and, in reverse, those who visit needle exchange sites could be seamlessly connected with clinical services and community resources they need to enhance their overall health, including substance use disorders (SUD) treatment services.

While people support the linkage between primary care and population health in theory, many wondered whether greater integration between DHS, DMH, and DPH would hamper collaborative efforts between public health and health care providers outside of the County's directly operated network. There is no reason why this must be the case. The agency's proper focus and mission should not be on the individuals served by DHS or DMH, but on the 10 million residents in Los Angeles County. To the extent that greater partnership between the County's health-related Departments helps to inform and improve the population health activities within DPH, this would benefit providers and individuals across the County. Also, while partnerships should not be limited to DHS and DMH, collaborations between DHS, DMH, and DPH are critical precisely because they focus on underserved, disadvantaged populations.

Integrating services at the point of care for those seeking services in the County

A commonly shared goal of all stakeholders, both internal and external, is that clinical services should be more completely and consistently integrated at the point of direct care delivery for individuals cared for within (or in clinics funded by) one or more County Departments even where the care is not provided directly by the County. This section focuses on how best to optimize care for this set of individuals.

A frequently cited 2013 data pull revealed that only ten percent of the total active DMH outpatient client population was among those empaneled to DHS directly-operated primary care clinics. People have suggested that this "10%" means there is relatively little overlap between the DHS and DMH population and thus little value to an agency that would prioritize service integration. The true population of overlap between DHS and DMH that is relevant for service integration can be considered in five broad groups.

1. Individuals active in the DMH system who use DHS as their regular source of primary care, i.e., the "ten percent".[4]

[4] The 10% figure documented in 2013 likely underestimates the current overlap between DMH's client base and DHS patients empaneled to directly-operated clinics because: 1) Data was pulled early in DHS' empanelment process. In 2013, ~ 250,000 patients were empaneled to DHS primary care clinics; today the figure is ~500,000. 2) The data match process is prone to error: since the Departments do not share a unique identifier, data matches are highly error-prone and tend to underestimate the true shared population.

2. Individuals active in the DMH system who have a stable source of primary care in private non-profit or for-profit clinics whose primary care is not funded by DHS; these are primarily, but not exclusively, Medi-Cal insured individuals, and may or may not use DHS and DPH for other clinical services.
3. Individuals active in the DMH system who have a stable source of primary care in the community clinic network as funded by DHS' My Health LA Program[5]; these individuals are exclusively uninsured.
4. Individuals active in the DMH system who have no stable source of primary care. They may be found in County or private hospital Emergency Departments (EDs), psychiatric EDs, urgent care centers, and inpatient units, or they may be completely disconnected from the physical health care system. If served by LA County's hospitals, they are in the overlap between the Departments despite not being engaged with primary care. If served only at private facilities, these individuals are not in the area of current overlap between DHS and DMH, but could benefit from a connection with a primary care resource able to provide integrated mental-physical health services.
5. Individuals with mental illness who are seen within County or private hospitals/clinics, but who are not actively engaged in the DMH system, having not received 5150 or other emergency services that would have enrolled them in DMH's database.

Given high rates of mental illness among Medicaid populations[6], the total population in groups 1-5 is likely to be large, even larger once the overlap of SUD is added. Of the above categories, groups 3, 4, and 5, and not just those in group 1, are the proper focus of service integration efforts. To the extent group 2 is currently well-served by their current mental health, physical health, and substance abuse services, the agency should leave their services untouched. Attention to these groups is important because those served within the County and in clinics funded by the County are some of the most disadvantaged, underserved and overlooked populations in the LA County. They are disproportionately low-income and may not be eligible for insurance. They are members of underrepresented minorities or groups who have long suffered health disparities, discrimination, with poor (or no) access to care. Some portions of this population come to the attention of mainstream society only when they are in crisis, when they present a personal and public safety risk, when they over-use emergency services, or when they are identified as imposing high societal costs. They may be part of particularly vulnerable segments of society: recently incarcerated, foster children and transitional age youth, disabled, and/or homeless. There are many individuals within the County who would likely benefit from coordinated mental health, physical health, and often substance abuse treatment services. A failure by the County to well serve these populations propagates and even risks increasing health disparities in LA County. The challenges inherent in addressing this dilemma are increased by the fact that Med-Cal and safety net providers for mental health services are already encompassed in one provider network whereas primary care services are provided by DHS, Federally Qualified Health Centers (FQHCs) and other independent practice groups and plans.

Examples of service integration models and efforts

In the past, the Departments have collaborated on a number of initiatives in certain geographies or for certain cohorts. Following are a few examples:

(1) Leavey Center: The Leavey Center in Skid Row provides a range of services for homeless individuals. DMH provides mental health services, DPH provides TB and radiology services, DHS and JWCH are funded by DPH to provide HIV medical care and medical care coordination services, and a community clinic and anchor tenant at the site provides primary care, dental and optometry services.

[5] My Health LA (and its precursor program) funds primary care at contracted clinics for 150,000 uninsured Los Angeles County residents.
[6] Rates of mental illness in Medicaid populations are over twice the rate as in the general population; among disabled Medicaid patients, mental illness prevalence is estimated to be approximately 50%. Kronick, M (2009). "The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions." *Center for Health Care Strategies, Inc.*

(2) MLK Psychiatric Urgent Care Center (UCC): DHS provides primary care services at the DMH-contracted MLK Psychiatric UCC, increasing access for clients with mental illness who prefer to seek medical care in a mental health setting. DPH provides contracted Substance Abuse Prevention and Control (SAPC) services.
(3) Health Neighborhoods: The DMH health neighborhood initiative is an effort to bring together regional providers across health, mental health, substance abuse, and community-based services to improve coordination of services in a specific community. Five pilots are currently active: Lancaster, Pacoima, Boyle Heights, MLK/Watts/Willowbrook, and Central Long Beach.
(4) Co-Occurring Integrated Care Network (COIN): COIN integrates substance abuse, mental health, and physical health care for AB109 clients who reoffended under probation supervision. Beyond DHS, DMH, and DPH, other partners include Probation Department, the District Attorney, Public Defender, and contracted providers.
(5) DHS-DMH Co-locations: DMH currently has clinical staff co-located at several DHS service sites; these staff accept referrals and provide some on-site treatment for DHS empaneled primary care patients. Some locations have been extremely successful; others suffer from a dearth of referrals for a variety of reasons.
(6) Integrated Mobile Health Team: An integrated primary care and behavioral health field-based team assessing and providing services to homeless individuals with co-morbid mental health and physical health and/or substance use conditions who are chronically homeless and highly vulnerable. The teams have demonstrated improvements in mental health symptoms, recovery from mental illness, and physical health symptoms and signs (e.g., body mass index, blood pressure) and a decline in ED utilization.

Successful examples of service integration are also found in the systems of care that support HIV-infected individuals. From the beginning, the HIV community has insisted on providing integrated physical health, mental health, and substance abuse treatment services to HIV-infected clients, a movement that was supported with federal Ryan White Care Act funding and supported through the initiation of the local Ryan White Planning Council. The Council worked diligently to bridge major differences across disciplines and agencies. While these and other successes should be applauded, they do not represent an integrated system of care for the residents of LA County. They are generally focused on specific populations or are present in only a certain facility or region.

Integration activities range in intensity from simple care linkages to more complex care models utilizing a diversified and highly-trained workforce. The specific opportunities to be pursued should depend on a number of factors including the needs and preferences of individuals served, their degree of connectedness to the current system, medical comorbidities, etc. Evidence-based models of service delivery, including those that support a range of different cohorts, should be prioritized for implementation. The design and health-related outcomes of these models varies substantially. Much has been written about the different models through which care can be integrated; if interested, please refer to one of the publications on this topic.[7] Rather than summarizing this excellent body of literature, this section will focus on the overall opportunities and benefits for clients/consumers/patients in LA County.

[7] While numerous publications exist, the following reports provide overviews of integration models, frameworks, and key success factors:
a) Agency for Healthcare Research and Quality, "Integration of mental health/substance abuse and primary care," No 173, 2008.
b) Institute for Healthcare Improvement and the Lewin Group, "Approaches to integrating physical health services into behavioral health organizations: a guide to resources, promising practices, and tools," prepared for CMS, 2012.
c) The Kaiser Commission on Medicaid and the Uninsured, "Integrating physical and behavioral health care, promising Medicaid models," 2014.
d) Millbank Memorial Fund, "Evolving models of behavioral health integration in primary care," 2010.
e) National Council for Community Behavioral Healthcare," Behavioral health/primary care integration models, competencies, and infrastructure," 2003.
f) National Council for Community Behavioral Healthcare, "Behavioral health/primary care integration and the person-centered healthcare home," 2009.
g) SAMHSA-HRSA, Center for Integrated Health Solutions, "A standard framework for levels of integrated healthcare," 2013.

Bi-directional co-location of primary care and mental health services to enhance access to care:

To the greatest extent possible, individuals should have the option to receive primary care and mental health services in the location where they are most comfortable. There are two general forms this could take: co-locating primary care services in mental health settings and co-locating mental health services in primary care settings. Both models can apply equally to directly-operated and contracted clinic sites, though the implementation steps will obviously vary.

In co-located models, physical health services would be provided by nursing and/or provider-level staff who can tailor treatment approaches based on the individual's risk factors for physical illness, medical history, and readiness to engage with the health system. On the mental health side, the individual's level of impairment and scope of need for mental health services will determine whether these services should be provided by members of the primary care medical team itself, with education and consultation provided by mental health staff, or by mental health staff directly. One summary of how this division of responsibility could work is provided in "Revised Four Quadrant Clinical Integration Model" as described by the Second Supervisorial District Empowerment Congress Mental Health Committee.[8] It presents a six-box matrix for how integrated services would be provided depending on an individual's physical health risk (high/low) and mental health risk (high/moderate/low). Despite the appeal of co-location, there is a sizeable gap between individual demand and what the system is currently able to provide.[9]

Primary care services co-located in mental health settings: For over a decade, those with co-occurring serious mental illness have been known to die more than 25 years earlier than people without mental illness, with the majority of the excess mortality stemming from largely preventable and/or treatable medical conditions.[10] There are multiple explanations for this finding. First, individuals with mental illness have higher rates of modifiable risk factors (e.g., smoking, obesity) and higher rates of adverse social factors (e.g., poverty, homelessness) than the general population. Second, individuals with mental illness may be uncomfortable or unwelcome in traditional medical settings, including primary care clinics. They may be fearful of new situations or may have had negative experiences in physical health clinics previously, in part due to the stigma associated with mental illness. Also, those with mental illness are frequently under-diagnosed and under-referred to primary care or specialty care services, despite their high risk for disease and the known physical effects of psychotropic medications. In the words of one stakeholder: "primary care just doesn't work for many [mental health] clients". Given the high stakes, taking time to strengthen and evolve the availability of primary care in mental health settings should be a high County priority. The operationalization of a sophisticated primary care-mental health integration model will take time to develop but is an important venture if we hope to reverse the decades-long trend of premature mortality among those with mental illness.

Mental health services co-located in primary care settings: Partly due to the intense stigma of mental illness, many of those seen in the physical health system "fly under the radar" and don't receive necessary mental health or substance abuse services, engaging only in the primary care (or other physical health) system where their less stigmatized medical illnesses are addressed but where their behavioral health issues are often undertreated. Even when an individual would accept treatment for mental illness, there are additional challenges in connecting them to care, both because of a failure by primary care providers to refer to mental health and failure of the system to translate that referral to a timely visit. Many individuals with mild or even moderate mental illness can be well-served by a medical home team if supported by the expertise and experience of mental health clinicians in identification, diagnosis, and treatment techniques, including use of

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h) SAMHSA-HRSA, Center for Integrated Health Solutions, "Advancing behavioral health integration within NCQA-recognized patient-centered medical homes," 2014.

[8] Second Supervisorial District Empowerment Congress Mental Health Committee, "Los Angeles County Mental Health Services 2014 White Paper," 2012.

[9] Blue Shield of California Foundation, "Exploring low-income Californians' needs and preferences for behavioral health care," 2015.

[10] Parks J, et al, (2006). *"Morbidity and mortality in people with serious mental illness."* National Assoc. of State Mental Health Directors.

recovery-based approaches. For other individuals, treatment by a mental health professional may be required, but could often still be performed in the physical health setting, enhancing access to and retention in care. These actions are currently being undertaken by DHS and DMH to some extent but could perhaps be accelerated in the context of an agency.

DMH and DHS have attempted to address this need previously with a basic co-location model in which DMH placed a psychiatric social worker in certain DHS primary care sites, while recognizing that successful co-locations between DMH and community clinics should also be supported. Although several of these sites have been in place for over three years, the volume of referrals has been lower than the suspected need in each clinic and providers have criticized the actual impact on access and linkage to care. There are many reasons for this, including a cumbersome referral system, slow ramp-up of mental health staffing and slow adoption by primary care providers in certain sites, and sub-optimal mechanisms for ensuring joint consultation and follow-up between providers. Some stakeholders pointed to successful examples of these DHS-DMH co-location efforts as evidence of what could be accomplished without an agency. Others argued that the challenges support the need for a new model to promote service integration.

Co-location can offer particular benefits to those with complex medical problems and disabilities. These individuals often require a broad mix of services including substance use treatment and mental health care but face unique challenges in navigating a complex array of physically separated services. One example where greater collaboration and integration could be specifically helpful is in meeting the needs of Traumatic Brain Injury (TBI) patients. TBI patients have a high prevalence and incidence of mental illness and substance abuse disorders, both prior to and following their injury.[11,12,13] Given the nature of this group's behavior, proper facilities are needed to help manage their complex rehabilitative needs. That said, models of care or funding resources for these patients are not currently available within the health care system.

While critical, physical co-location is only one approach. Clinics could also be assisted in helping to evolve partnerships in a deeper and more deliberate way, such as the development of shared care plans, merged care management functions, etc. An agency might, for example, choose to employ the work of care integration and mutual plan development already occurring in the Health Neighborhoods.

Improved access to substance abuse services

It is estimated that over one quarter of US residents will suffer from a substance use disorder (SUD) in their lifetime.[14] These individuals tend to be heavy utilizers of health services, incurring between two and three times the total medical expenses as those without SUDs.[15] Similar to the statistics for individuals with a mental health condition, individuals with a SUD die on average 26 years earlier than the general population due to modifiable risk factors and physical health problems related to their long-term substance use.[16] Also, despite frequent use of public and private EDs, psychiatric emergency services, urgent care clinics, and mental health facilities, very few admissions to SUD facilities result from referral from

[11] Model Systems Knowledge Translation Center abstract: "TBI Model System Collaborative Study of Amantadine for Post TBI Irritability and Aggression" Accessed March 23, 2015 at: http://www.msktc.org/projects/detail/1059.
[12] Kolakowsky-Hayner, SA (1999). "Pre-injury substance abuse among persons with brain injury and persons with spinal cord injury." *Brain Injury, 13*(8), 571–581.
[13] Ohio Valley Center for Brain Injury Prevention and Rehabilitation. (1997). "Substance use and abuse after brain injury; A programmer's guide."

[14] Kessler, RC, et al, (1994). "Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey." *Archives of General Psychiatry, 51*(1), 8-19.
[15] Thomas, MR, et al, (2005). "Prevalence of psychiatric disorders and costs of care among adult enrollees in a Medicaid HMO." *Psychiatric Services, 56*(11), 1394-1401.
[16] Oregon Dept. of Human Services, Addiction and Mental Health Division (2008). "Measuring premature mortality among Oregonians."

other health professionals[17], which provides evidence of a disconnection between the health care system and the SUD delivery system. As a result, individuals with SUD fail to receive the well-documented benefits of SUD treatments, receive physical health care in isolation from their medical risk factors, and the County fails to achieve the cost savings that accrue when SUD services are effectively integrated or coordinated with other health care settings.

Recent legislative changes under the ACA and its renewed focus on the importance of parity present an unprecedented opportunity to end the past forty years of separate and unequal resources for the treatment of SUDs. Currently, the Substance Abuse and Mental Health Service Administration (SAMHSA) is considering changes to federal substance abuse confidentiality rules, in part due to their acknowledgment that the strict consent requirement of the Federal Substance Abuse law, commonly referred to as Part 2, make it difficult for programs to participate in care coordination initiatives that facilitate the sharing of health information. These legislative efforts, combined with new knowledge from basic, clinical, and health services research over the past two decades has set the stage for a new public health-oriented approach to managing SUDs with the same insurance options, new healthcare team composition, clinical goals, and clinical methods analogous to those used to manage other, chronic illnesses such as diabetes, asthma, or chronic pain.

Change in SUD treatment models are much needed, as contemporary addiction treatments are for the most part based upon outdated concepts about the nature of addiction and, in turn, the nature of the care needed to bring about recovery. For the most part, existing treatments for addiction are "program-centered" rather than "person-centered" – everyone gets the same care regardless of the type of addiction or coexisting medical and/or social problems. Because everyone essentially receives the same care, there has not been a need to evaluate other influences including issues related to employment, legal or family issues, and medical/psychiatric problems that could affect the course of recovery. Previously, health coverage linked to SUD programmatic care has been time- or session-limited, and the financial limitations of health coverage have restricted the range of treatment components (tests, medications, therapies, family support services, etc.) available within any treatment program.

With the augmentation of the Drug Medi-Cal (DMC) benefit and the need to reestablish and augment the DMC provider network, the County should specifically explore opportunities to expand DHS' and DMH's clinic and workforce capacity to provide substance abuse services. A recent Medi-Cal managed care requirement for primary care providers to offer alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) has drawn attention to substance abuse, but has not extended to actual treatment capacity. An agency could support DPH in creating a robust substance abuse service network in LA County and, in turn, enhance the current low penetration of SUD services throughout the County. Currently, outpatient substance abuse services are primarily contracted out. DPH and DHS need to explore how substance abuse screening, counseling, and treatment might be offered within existing DHS primary care clinics or DMH mental health clinics. This may be done through training DHS staff in how to manage SUD patients by employing more focused workforce models such as greater reliance on certified substance abuse counselors as DMH has been doing for a number of years. In this instance, the integration of certified SUD counselors into DHS clinics, as is already the case in DMH clinics, would complement the professionalization of the SUD workforce to create a healthcare workforce that is more similar across systems of care (DHS, DMH, and DPH) and whose training reflects the individualized needs of whole-person care.

While the role of psychosocial interventions and more recovery-focused approaches should be strengthened, advances in pharmacotherapy have also led to an increasingly medicalized model for delivering substance abuse treatment, including office-based pharmacologic treatment interventions such as Buprenorphine (Suboxone) for opiate addiction and Naltrexone for alcohol use disorder. These changes in the substance abuse field require a diversification of the SUD workforce to include more highly trained individuals, such as physicians, nurses, psychologists, and social workers. Greater

[17] According to an analysis of CalOMS data accessed in FY12-13 by DPH SAPC staff, only 2% of admissions came directly from a health professional referral.

use of these professionals within mental health and physical health settings would complement the services provided by SUD counselors, and allow for the development of a system of care for substance abuse that can more comprehensively and efficiently meet the needs of persons with SUD. In the transition toward more integrated systems of care, the agency model will play an important role in ensuring that the level of professionals in substance abuse mirror those in physical and mental health in order to allow for more effective coordination and communication. As it expands capacity to provide substance abuse services, the County should pursue possible certification of DHS and DMH clinics as DMC providers. This would not only improve care for individuals using the County's delivery system, but would also help to support the overall success of the expanded DMC benefit in LA County by increasing access and network coverage. DMC certification would also allow the County to be reimbursed via DMC for office-based pharmacologic interventions and other services for which a dedicated revenue stream does not currently exist.

Improved access to quality substance abuse treatment will have positive downstream effects on overall population health goals, including both physical and mental health: just as it is difficult to remain healthy while hungry or homeless, managing disease and becoming healthy is near impossible while addicted. In addition, individualized approaches to illness management for individuals suffering from alcohol and other addictions will require close coordination across the Departments to sustain self-managed recovery – specifically, sobriety, personal health, and good social function. Transitioning individuals through a system of care that is coordinated with all other aspects of their health will allow providers to anticipate challenges and intervene promptly to help patients prevent relapses, reduce ED visits and hospitalizations, and improve health outcomes.

An additional advantage of having DMH and DHS provide directly operated services is that the County becomes directly familiar with the practice, approaches and operational realities of delivering these services. This firsthand experience allows the County to be more knowledgeable and discerning purchasers of substance abuse contracted services and enhance the ability to design more accessible and integrated programs with its existing contractors as has been DMH's historical experience.

Beyond SUD network expansion, another potential benefit of greater linkage between substance abuse and primary care is a more coordinated strategy for managing prescription drug abuse. With the expansion of Medi-Cal, it is paramount for direct service providers such as DHS to remain vigilant around opiate diversion, misuse, and abuse. Bringing DPH contractor expertise and energy together with DHS providers might allow the County to improve approaches to preventing and managing opiate abuse and diversion. In turn, these improvements could be shared and adopted in contracted clinics.

Finally, greater collaboration through an agency could help to identify opportunities and mobilize resources to expand access to inpatient rehabilitation or residential services, particularly important with the expansion of the DMC benefit under the ACA. The agency may also choose to prioritize creation of more novel approaches to detox, such as integrated sobering centers supported by physical and mental health, housing, and other social services. One program that could serve as an example for the County is the Restoration Center in San Antonio, TX. The Restoration Center is a detox and substance abuse treatment center that provides assistance to homeless individuals struggling with alcohol and drugs and those with severe mental illness. The Restoration Center provides 48-hour inpatient psychiatric unit, residential detoxification, a sobering facility, injured prisoner programs, outpatient substance abuse treatment including intensive outpatient substance abuse counseling services, in-house recovery programs, linkage to housing, and job training. More than 18,000 people pass through the Restoration Center each year. The Center has saved the city of San Antonio more than $10 million annually, largely from reducing the inappropriate use of emergency rooms, unnecessary hospitalization, and detention in jails and mental health facilities.[18] Other benefits include increased support for homeless populations and

[18] http://www.chcsbc.org/innovation/restoration-center/; http://kaiserhealthnews.org/news/san-antonio-model-mental-health-system/

greater efficiency in the use of law enforcement. "San Antonio realized that it's more cost effective to provide mental health services and supports to people on the front end, rather than pay for jail beds and prison time."

An agency would also exert greater leverage in advocating for the funding necessary to support these facilities and programs, such as by leveraging opportunities to influence Medicaid coverage regulations and design of opportunities in the upcoming Section 1115 Waiver (e.g., inclusion of sobering center services for uninsured individuals in the proposal for a merged Disproportionate Share Hospital / Safety Net Care Pool fund). The approval of California's DMC waiver, which would shift DMC financing to a per user per month capitated payment would also help to further incentivize novel approaches to managing this chronic disease and the high associated health and social costs.

While stakeholders voiced mixed views of the agency model itself, they were nearly unanimous in supporting any changes in the County that could improve support for a full continuum of SUD services based on medical need. Citing extremely low penetration rates at less than 20%, stakeholders commonly commented that "it certainly couldn't get any worse." Stakeholders cited the need for treatment on demand and simultaneous access to multidisciplinary services as "the only things that are proven to make a difference for real people in crisis." They pointed to screening and early intervention for both alcohol and other drugs, such as through use of SBIRT, as offering the best hope for changing the course of disease. "We treat substance abuse, a chronic brain disease, episodically in EDs, psychiatric EDs, and in jails, and then we wonder why it isn't working." As with the integration of mental and physical health, the County needs to develop an organized system of care for the management of SUD, a model that offers interventions for individuals across acuity levels and at different stages of willingness to engage in their recovery. Integrating all three service spheres - mental health, physical health, and substance abuse - into the same site in a "one-stop shop" model would help each Department better connect individuals to the right service, at the right time, in the right place in a way that is efficient and person-centered.

<u>Complex care programs</u>:

One of the most important agency functions could be to better align programs currently underway in each Department to help support and manage the most complex individuals within each service area. Although each Department's programs are distinct, they often share similar elements. These include: (a) a focus on a specific population; (b) use of specific demographic, clinical, or utilization characteristics to identify the target population; (c) innovative uses of often non-licensed workforce members; (d) services provided both within and beyond the four walls of a clinical setting; (e) lack of dedicated funding streams. There are a variety of synergistic opportunities to align certain aspects of these programs:

(a) *Program development:* The most important way the agency might support the development of complex care management approaches is to lead the Departments to adopt a joint program design and implementation approach, including non-County partners and providers when appropriate to do so. The experience of Project 50, which DMH facilitated in 2007 with a goal of permanently housing fifty of Skid Row's most chronically homeless individuals, is a concrete example of a project that successfully engaged health and social service County Departments for the benefit of individuals and the community.

(b) *Risk stratification and identification:* Currently each Department determines its own eligibility criteria for complex patient and high-utilizer programs, usually based on requirements of associated funding streams. Because the criteria are often similar but not overlapping, certain high-cost, high-need patients may qualify for a program with a certain set of benefits in one Department but not for a program with separate benefits in another. This makes it difficult and confusing for providers, both within and outside the County, to know how best to connect individuals with the services and programs they need. Departments should consider jointly determining where the overlap is in their respective populations and how to structure eligibility so the benefit is to the most complex individuals possible at the County, rather than Department level without incurring fiscal liabilities and audit issues.

(c) *Data/analytics:* These programs are often resource-intensive and thus require heightened scrutiny as to their performance and value. Under an agency model, the Departments might synchronize their approaches to measurement and analysis (where there are opportunities to do so), reducing duplication of analytic activities, facilitating response to the varying needs of funders, and allowing for more robust program analysis which can inform which programs should be further supported and which may require alteration.

(d) *Training:* Given the high use of non-licensed staff (e.g., community health workers) and the need for constant recruitment due to staff turnover, the agency model might help centralize scarce but critical expertise and adopt a coordinated, efficient way for the Departments to train and educate this part of the workforce. This may mean, for example, jointly partnering with labor- and community-based agencies expert in the use and training of certain non-licensed personnel while maintaining opportunities for those with lived experience.

Apart from the needs of highly complex populations, individuals who use services in more than one Department would benefit from greater commonality in departmental forms and electronic documentation tools (e.g., forms for registration, consent, and care planning, population registries, screening and discharge planning tools). Greater alignment in tools would allow for development of more efficient and transparent care management approaches, shared assessments of clinical quality and would help other County departments and community-based organizations to more consistently interact around specific individuals they share in common. Aligned documentation tools could also facilitate greater use and effectiveness of multi-disciplinary team meetings for high-risk populations including youth in foster care, re-entry populations, homeless individuals, and fragile elderly.

<u>Expansion of the recovery model into physical health care settings:</u>

The recovery model, or recovery approach, emphasizes an individual's capacity to change and gain control and meaning in their life through empowerment, hope, community, and attention to the whole person. DMH's community mental health programs are centered around the concept of recovery, rather than on a "medical" model for treating mental illness. This recovery model was developed using concepts from client advocates and SUD 12-Step communities. While often used in the mental health context, an emphasis on recovery need not be reserved only for populations with serious mental illness. Housing programs (e.g., DHS' Housing for Health program), care models for those with un-curable chronic medical conditions, and many approaches to substance abuse treatment often employ a recovery philosophy with good results. Despite wide and growing recognition of the value of recovery approaches, use of the model could be expanded across the County. For example, DHS could expand use of recovery in managing individuals with chronic pain or chronic conditions, particularly those not well-served with available medical interventions or pharmaceuticals. Individuals with diabetes, chronic pelvic or abdominal pain, arthritis, or headaches could benefit from a greater emphasis on recovery. An agency could help spread these practices across the Departments, making available additional treatment options based on an individual's level of commitment to engage and change.

<u>Greater linkage to care by embedding primary care in DPH direct service clinics:</u>

When DPH became a separate department in 2006, it retained responsibility for operating direct clinical services such as STD screening and treatment, TB control, and immunization clinics. Both DHS and DPH acknowledge there was little coordination between these services and primary care prior to the separation. By embedding primary care in DPH clinics, Angelenos who rely on DPH clinics for certain focused services could have the option of accessing more comprehensive services at the time of their visit. Although STD or immunization services might be the initial draw, co-locating a nurse or provider would help identify those with or at risk for diabetes, hypertension, alcohol or other substance abuse disorders, domestic violence, or other potentially mutable conditions that benefit from early intervention.

For childhood immunization services, offering, but not requiring, well child services could increase the number of school aged children who are receiving necessary anticipatory guidance, being screened for common chronic diseases prevalent in

childhood, and assessed for developmental or behavioral issues that can impede school success and achievement. Beyond the benefits in access and care quality, an additional advantage of this approach is the opportunity to enhance the system's funding by assisting with eligibility determination and enrollment for Medicaid, with linkage to the person's provider of choice either within or outside of DHS. Finally, there is an opportunity to better integrate mental health screening tools into both DPH and DHS pediatric clinics, actions that could help make important early interventions for at-risk children. Literature shows that most serious mental disorders begin early in life (50% by age 14 and 75% by age 24[19]) but, unfortunately, less than half of children with such disorders receive treatment appropriate for their condition[20]. County clinics serve a number of children who are at high risk for behavioral health problems and who could qualify for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits through Medi-Cal but whom are not routinely and systematically screened. Implementation of standardized screening tools for mental illness could be an important way to identify and link individuals with the mental health services they need and are entitled to.

Tuberculosis (TB) services:

Due to prompt intervention and intense case management by DPH's TB control program, TB rates are declining in the County. However, there are still a number of individuals undergoing community-based treatment for TB or who require ongoing surveillance by DPH. Inpatient and highly specialized outpatient care (e.g., pulmonary procedures) are provided by DHS but providers in the different Departments are unable to easily and quickly exchange health information for care and treatment purposes. Advances in achieving a unique patient identifier, common medical record (or linked systems) would help, as would a greater level of joint care planning. DPH and DHS could also rely on one another's ancillary services (e.g., radiology) based on availability in certain locations with resulting cost-savings. Bringing together the housing efforts within DMH and DHS with the TB housing efforts of DPH might allow LA County to better serve homeless TB patients. Finally, better coordination between DPH's surveillance and control of TB within the jail and DHS' inmate specialty health services could allow for a more efficient approach to the management of possible jail TB, including fewer unnecessary admissions to LAC+USC Medical Center to rule out TB, a costly evaluation in a hospital setting.

Addressing major service gaps for vulnerable populations

A key driver toward change is awareness that the County is not making sufficient progress in tackling some of the most important health issues for at-risk populations and that perhaps, more could be done were DHS, DMH and DPH led together. They are rooted in the social and physical environments in which people live and require a concerted effort with internal and external partners. Whereas many individuals have found excellent services and support from County-provided or funded programs, this success has not penetrated some of the more challenging and vulnerable groups: foster care, transitional age youth, incarcerated individuals, re-entry populations, homeless individuals, and those in crisis. There are many reasons why it is challenging to effectively address the needs of these populations. First, solutions must involve not only DHS, DMH and DPH but at least one, and many times more than one, other County Department (e.g., DCFS, DPSS, Probation, Sheriff), and often require client/consumer/patient hand-offs between Departments. While the agency will not involve these other non-health departments, it will need to dedicate attention to making these partnerships effective. Second, financial investments and programs are often designed by Departments based on available categorical funding streams, each with established restrictions, without attention to other Departments' funding and activities. When collaborative and integrated service planning and provision do occur, they attempt to "fix" the problem with additional

[19] Kessler RC, et al, (2005). "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication." *Archives of General Psychiatry, 62*(6), 593-602

[20] Costello JV, et al, (2014). "Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey – Adolescent." *Psychiatry Services, 65*(3), 359-366.

downstream interventions, seldom capitalizing on opportunities to alter upstream funding issues or affect initial program design. The agency allows the County to approach these challenges as a broader health system issue rather than from the vantage point of independent Departments each focusing on their piece of the picture. This broad systems approach can allow for a different set of interventions and strategies to emerge that may prove more fruitful than the status quo. Success in this regard would have a spill-down effect across the County, including for populations that aren't in these highest risk groups. "Focus on the most difficult problems. If you solve system problems for the most disadvantaged, you end up helping everyone."

Foster Care and Transitional Aged Youth (TAY):

On any given day, LA County has 18,000 children in the foster care system and 13,000 being investigated for physical abuse, sexual abuse, or neglect. Although the Department of Children and Family Services (DCFS) is the lead agency, DMH, DPH and DHS also have roles in serving these children and their families. Study of the recent deaths of children in the County reveals cracks that exist between the investigative and support/care services for these children. These deaths have often involved a breakdown in communication between the involved Departments and a lack of connection between what is happening in the child's home or community and the findings by providers in medical or mental health settings. The recent activities of the Blue Ribbon Commission have brought together many County departments to refine and redeploy resources around how public health nurses assess and refer children vulnerable to child abuse, how more seamless and continuous care can be provided to children in foster care, and how we support children who are difficult to place in safe and appropriate foster care because of age, medical, or behavioral health conditions. Particularly with the creation of the Office of Child Protection, a health agency can be a tremendous force in helping to coordinate the three health-related Departments regarding child protection and foster children.

An additional opportunity under the agency model is in the implementation of whole person care for DCFS-involved children and youth. Despite improvements in services with the implementation of the Katie A. settlement agreement and the Medical Hub Clinics, mental health and physical health services for children and youth in foster care still operate on parallel tracks and are not well coordinated, leading to delays in care, poorer health outcomes, and unnecessary duplication of services. For example, medical providers at the DHS Medical Hub Clinics are often unable to determine whether a child is receiving mental health services or to assess the child's progress, and DMH-contracted Multidisciplinary Assessment Team (MAT) providers conducting comprehensive assessments of newly detained children operate separately from the Medical Hub system, with minimal or no sharing of information between the systems. In addition, foster parents and relative caregivers are often challenged by the need to navigate different systems of care and by the sheer number of agencies and appointments to which they must bring children in their care. To the extent that an agency can provide opportunities for one-stop services and care coordination, the stresses on foster and relative caregivers and families can be reduced.

Transitional Age Youth (TAY) (often defined as those 16-25 years old, including but not limited to those who age out of the LA County child welfare and juvenile probation systems) face numerous challenges in attaining self-sufficiency and have been shown to have poorer outcomes than their peers in educational attainment, employment, housing stability, and mental health. Crossover youth with experience in both the child welfare and juvenile probation systems are at particularly high risk for incarceration, poverty, and high reliance on public benefits and services. County departments have developed goals and programs aimed at increasing TAY self-sufficiency; however, services are still fragmented. DPH, DHS and DMH each provide services that are highly relevant for this age group, including sexually transmitted infection and SUD prevention and treatment, care for chronic and acute medical conditions, mental health outpatient treatment and crisis intervention, and transitional and permanent supportive housing. There is a need for greater coordination of these services, improved information sharing, and much-needed consolidated care coordination/case management services, particularly for high-risk subgroups such as crossover youth and Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning (LGBTQ) youth.

Re-entry and incarcerated populations:

The re-entry population is a diverse group that includes those coming from the State prison system and the County jails. The former group is largely people returning to LA County after years of being away. The latter includes a wide spectrum, ranging from those who quickly cycle through jail to those who have served multi-year sentences. The diversity and unpredictability of when and from where (court, jail or a prison) people are released is a primary driver of the complexity of re-entry services: it is difficult to plan services for an individual when his/her re-entry date, time, and location are unknown and/or unreliable. This challenge is multiplied because the re-entry population has need for services from all three of the County's health departments as well as other County departments. While difficult, intervening in this group is critical: people leaving jail and prison have a 12-fold higher likelihood of dying in the first two weeks following release then someone in the general population.[21] The County should be held accountable for narrowing this disparity. A shared approach to addressing the health needs of the re-entry population could enhance pre-release planning, making it easier for this at-risk population to access services without gaps or duplication.

One relative success in integrating care among re-entry populations has been the County's AB109 experience. Under the AB109 effort, many County departments have come together to serve an at-risk and vulnerable re-entry population. With CEO support, the health-related Departments have co-located staff, allowing them to work together and share responsibility in creating a system that coordinates care and ensures timely access for re-entry individuals, often able to successfully trouble-shoot very difficult cases. Although there is more work to do under the AB109 program, such as a need to enhance housing and supportive services beyond the current 90-day transitional housing options available, the Departments have demonstrated the impact of working together to assist difficult populations.

Under an agency-led approach to re-entry service planning and coordination, there is an opportunity to create truly integrated and not just coordinated and co-located services. Currently, each Department has or is developing programs that target a specific subset of the re-entry population. These programs are mostly created independently from the other Departments. Stakeholders identified many opportunities to bring services together and provide more seamless and one-stop service provision. As examples, DMH has a program targeting the mental health needs of formerly incarcerated women that would benefit from augmentation of onsite medical services. DHS is planning a transitions clinic at the MLK medical campus to link the sickest of the re-entry population coming out of the County jail system with continuity health services; existing campus mental health and substance abuse services are being leveraged to serve this population. Stakeholders also discussed the opportunity to create and use assessment and care coordination tools. Developing shared metrics and jointly reporting progress toward these metrics, as has been done with AB109, was also identified as a strength of an agency-led re-entry service planning effort. Under the ACA, the largely male, low income re-entry population has gone from being majority uninsured to having near universal eligibility for coverage through Medicaid expansion. Given the federal funding that now follows these individuals, re-entry programs can be more easily prioritized and funded.

While re-entry services are an obvious place for more robust departmental and community engagement, improving services to those currently incarcerated is also important. DPH, DMH and DHS provide services to LA County Sheriff's inmates, alongside care provided directly by the Sheriff's Department itself. The care is currently disconnected and information in one area is veiled from the others. While a separate memo will explore major issues in jail health services and options for restructuring services among/between the involved County departments, it is worth noting here that stakeholders agreed that improving jail health services, particularly at the point of release, would have immense benefit when it comes to planning for re-entry services. Nurse and provider assessments, diagnostic studies, medication lists, labs, and problem lists should follow the individual into the community so their re-entry care plan can be appropriately informed. For example, if a

[21] Binswanger, IA, et al, (2007). "Release from prison – a high risk of death for former inmates." *NEJM, 356*(2), 157-65.

person receives an MRI study in jail, the result should be shared with community providers thereby obviating the need for another study and improving the timeliness of getting the individual to the appropriate next step in care.

Homelessness

There are over 50,000 homeless people in Los Angeles[22], and 373,000 individuals report being homeless or marginally housed at some time in the past five years[23]. These individuals are frequent users of emergency services, ricocheting through County EDs, psychiatric EDs, medical and psychiatric inpatient units, the street, jails, residential substance abuse treatment, and homeless shelters. Study after study in Los Angeles and the rest of the nation indicate that greater coordination among health care providers and other systems can change this harmful and costly pattern of care.

To a large extent, persistent homelessness in LA County and the rest of the nation stems from lack of affordable housing and poor integration of critical services homeless and low-income people need to lift themselves out of poverty. Health care plays a critical role given the clear connection between poor health and poverty. In looking at neighborhoods with high rates of homelessness, such as Skid Row, the evidence is overwhelming that the safety net has failed homeless people. Multiple health-related services are needed to effectively assist homeless people who are most often struggling with complex and overlapping health issues. More common than not, homeless people have unmet physical health, mental health, and substance abuse treatment needs. For homeless people, treating the "whole person" is a critical component of their path toward survival, recovery, and residential stability.

Notwithstanding many efforts to provide greater coordination among the health Departments on the ground, the physical health, mental health, and substance treatment services remain largely distinct. While there is some coordination, successful programs benefit only a handful of patients each. Many community members are confused as to how to access health and housing services and how to interpret or use the myriads of forms each Department uses. It is common to hear "I don't know how to get somebody into primary care" or "no matter what I've tried, I can't access mental health services for my patient" in a way they want to receive care, or "there is no housing for people who are currently using substances". This dysfunction has real consequences for people desperately trying to make a change in their lives. The fact that a case manager working with a homeless person has no clear path to assemble needed services across the spectrum of health care, keeps that person homeless and revolving through the hospitals, jails, and streets, at great cost to that person's health and the County's finances. Given the natural dynamics of three separate health Departments in terms of philosophy, funding rules, accountability, program design, and housing-related priorities, it remains difficult to bring all the resources together that are necessary to make meaningful and course-changing interventions in the lives of homeless people.

Ending homelessness starts with engaging people on the street and at the point of discharge from institutional care (e.g., hospitals, mental health facilities, jail). In order to be effective, outreach staff need to have a broad range of tangible resources at their disposal including access to detox and other substance abuse treatment services; crisis and on-going mental health services; urgent and primary care; and interim and permanent housing. This should also include supportive housing, which is widely viewed as key intervention for homeless people (and other populations exiting institutions such as jails, inpatient psychiatric facilities, and residential treatment). Supportive housing strives to provide a "whatever it takes" approach to helping residents recover and thrive, including access to a wide range of medical, social, and logistical supports. The three health Departments hold the keys to all of these different types of housing services and resources. However, the reality is that the right combination of services is rarely available at the moment they are needed, or in the way that the individual prefers to receive them. Many stakeholders commented that they felt existing funds could be better leveraged in

[22] According to the Los Angeles County Homeless Services Authority biannual count of homeless individuals, there were 57,737 homeless individuals in LA County in 2013.

[23] Los Angeles County Health Survey, 2011. Reflects those who reported being homeless or not having their own place to live or sleep in the past five years.

an integrated model to solve this problem. Under an agency model, it might be possible for funds to be more easily braided in such a way that a full spectrum of physical and behavioral health (including substance abuse) and housing services would be available to homeless individuals. As one example, individuals with serious mental illness are not able to access housing using DMH's resources unless they have an open case with DMH or its provider network based on interpretations of restrictions on the sources of funds. This common problem could be addressed in a two general ways: by creating new ways for people to engage in mental health care (e.g., via primary care co-locations) before they are housed in a way that may be acceptable to the patient, and by creating less restrictive shared housing and service entry criteria that rely on different mechanisms to verify an ability to use certain funding streams or by actually pooling funding behind the scenes. The ACA, through for example expansion of the Drug Medi-Cal benefit and treatment of mild to moderate mental illness, presents a fresh opportunity to approach this problem in new ways. Overall, the homeless population could benefit tremendously from a more integrated approach to service delivery.

Psychiatric emergency services:

Overcrowding of psychiatric emergency service (PES) facilities is a longstanding problem, adversely affecting public and private hospitals and the individuals and families they serve. Beyond the human cost for the person in crisis, PES overcrowding also results in a greater risk of violence toward patients and staff and extended wait times for ambulances and law enforcement when ED staff members are not able to safely transfer individuals to ED care immediately after arrival. But more than this, it is a canary in the coal mine, reflective of deep societal problems, challenges in the health system's ability to fully meet the demand for health and often social services, and problems moving people efficiently between varying levels of care. It is often assumed that EDs and PESs, as well as LPS-designated[24] urgent care facilities, are filled past capacity because of a shortage of inpatient mental health beds in the County. While this is true on occasion, particularly for individuals with characteristics that make them difficult to accommodate, such as registered sex offenders, pregnant women, individuals with comorbid medical issues, etc., it is not generally the case. On any given day, over half of DHS' 131 staffed inpatient psychiatric beds are filled with individuals who no longer require acute inpatient admission but for whom a placement deemed appropriate by the discharging physician is not available. A similar situation is prevalent in private EDs and inpatient psychiatric units.

Multiple collaborative efforts have attempted to address the problem over the years. DMH has long co-located case workers in DHS inpatient psychiatric units in an effort to assist with discharge planning and placement options immediately after admission, freeing up beds for those in the PES. Still struggling with discharge delays, DHS and DMH have partnered more recently on an "all hands on deck" discharge approach which has yielded dramatic results but has not proven sustainable. DMH has increased the level of engagement with law enforcement to link field personnel with mental health training and divert people whenever possible to non-ED settings. DMH has also opened additional urgent care facilities able to serve as alternative destinations for a portion of individuals who would otherwise be transported to the PES. DHS has also partnered to expand the capabilities of one such urgent care facility. DMH's new urgent care center in Sylmar opened in 2011 as a non-LPS designated facility and, as a result, was unable to play a role in decompressing the chronically overcrowded Olive View PES located down the street. After several years of discussing various possible solutions to this problem, DMH and DHS have agreed for DHS to assume responsibility for operating and staffing the locked portion of the urgent care center, a move which will allow the facility to begin serving people on involuntary holds 24/7. Despite these and other initiatives, the census in the three County PESs has remained at twice or three times the facility's physical capacity for years.

Much more should and can be done to accelerate the movement of patients through the continuum of care. Below is an example of steps that could be taken to address challenges meeting the needs of patients in psychiatric emergencies.

[24] LPS (Lanterman Petris Short) designation refers to the ability of a facility to accept patients on psychiatric holds.

1) The agency could support DMH and DHS in setting a collective vision for managing psychiatric emergencies, focused on getting people to the right level of care at the right time. Individuals should not wait long for acute services and, similarly, those ready for community-based placements should not be slated for or kept in more restrictive types of care. This philosophy should apply county-wide, to both public and private hospitals.
2) The resources and budgets of each Department's investment into acute services, as well as those outpatient services that support discharges from the acute system, should be transparent.
3) These resources should be (a) maximally matched by federal funds (via the Waiver and other mechanisms) and (b) flexible enough to purchase services or placements which are new and innovative in their function and approach, such as greater use of acute diversion units and crisis residential beds.
4) The County should actively engage with private facilities on new strategies to support acute psychiatric services. This includes making sure County investments in psychiatric services in non-County facilities are strategic and maximize the benefit for all those served by the County.
5) The County should develop a closer partnership with the custody arm of the Sheriff's Department, as well as other law enforcement agencies, which provide care and shelter to many of the sickest mental health clients/consumers so these individuals are better connected to outpatient services upon release.

Streamlining access to care

While the clinical care in County facilities is often excellent, the process of getting connected to that care can be challenging. In many stakeholder sessions, individuals would come forward describing their satisfaction with the care they receive in the County and their anxiety or fear that the agency would disrupt the services they have come to rely on. Yet in listening to these stories, they frequently started with a description of how difficult it was for the individual to get established in care in the first place. They described weeks, months, and in some cases years, of being referred from place to place, both within the County system and between private and County providers, of having to fill out an overwhelming amount of paperwork, of having appointments cancelled without notice, of having their records not available when they went to the next site of care.

A great deal of time is spent discussing a "no wrong door" approach to accessing care and services. Despite the attention the topic receives, there are still a variety of doors, many of them "wrong" or at least ineffective at linking people to the services they need in a client-centered, efficient manner. The redundancy and waste in the system is striking, as is the impact on customer satisfaction, retention in care, timely access to services, service coordination/rationalization, reimbursement, and ultimately, quality. While people acknowledge this current state and support the development of a coordinated, rational way for individuals to access the system, the operational barriers to making true headway on the issue are sizeable. "No one knows what services are available across the whole continuum, much less how to get your patients to access them. It's a black hole."

Screening tools; referral criteria, protocols, and tools; consents and authorizations; patient financial services policies and protocols; unique identifiers; registration and check-in procedures; and preferred points of entry to services are not aligned across Departments. Even if hypothetically consistent, which they are not, the duplication in these processes is tremendous, in large part because the Departments do not share a common identifier between one another so cannot tell in real-time when someone is known in another part of the County. DMH has access to the services provided in its network of care, but may have trouble matching those with DHS provider records. "You have no idea the number of times I had to fill out paperwork asking the same questions. Everywhere you go it's the same thing. I have to start from scratch every time. Doesn't anyone talk to each other?" Contracted service providers outside of mental health also lack a common identifier and often cannot easily refer individuals to one another. Despite being well-established in one Departments' system, that Department must first send them, either physically or virtually, for referral processing, or force individuals to

start over by telling them to dial a 1-800 number to access mental health services or to go to emergency or walk-in sites to access physical health care. This creates unnecessary delays in care and is a source of immense aggravation for individuals.

The solution lies in streamlining and rationalizing the multiple different processes, beginning with identifying a particular need for a particular person and ending with an encounter appropriate to that person's need. Common or at least consistent referral and financial screening processes and protocols and an ability to share demographic and basic financial information are essential. A critical piece of the puzzle is the establishment of either a unique identifier or Enterprise Master Patient Index (EMPI) able to be used across the system; this is already in the development in a way that is compliant with all relevant privacy laws. Without this, it will not be possible to fully capture opportunities in streamlining access to care. While it sounds straightforward, achieving this degree of alignment is immensely complicated, requiring numerous changes in IT systems, staff roles and workflows, and clinical practices. Some believe that without a single entity prioritizing the end goal, it will not be realistic for the County to accomplish the necessary steps.

Using information technology, data, and information exchange to enable service integration

Information technology (IT) is a key enabler of overall service integration goals and of efforts to enhance system access. The shared benefits of IT integration include the ability to enhance providers' access to information on individuals using services across Departments, thus improving service delivery and care coordination; improve an individual's experience of care and eliminate redundant processes for those receiving services from more than one Department; and increase the ability of Departments to perform population-based analyses for program planning and evaluation.

Electronic Health Record (EHR) and Information Sharing: Many people agree that the optimal solution for LA County would be a single EHR using one unique identifier assuming the EHR could meet the differing needs of directly-operated and contracted sites without compromising different documentation, reporting, and care delivery methods. Operational efficiency, data quality, and customer experience can be optimized by having all parts of a health care organization use a single, shared EHR. Patient/client privacy and security can be preserved if the Departments progress to use of a single system: modern EHRs are architected in a manner that allows for tight control over privacy and security of Protected Health Information (PHI), segmenting data so it can only be accessed by an appropriate resource. Modern EHRs also maintain audit trails of all records accessed as well as the specific information viewed. While there is broad agreement on the value of a shared EHR, there is also a shared recognition that achieving this goal will not be quick or easy, and should not be rushed. Each Department is at a different place in its own EHR process.

- DHS has completed implementation of its integrated enterprise EHR, a Cerner product referred to as ORCHID (Online Real-time Centralized Health Information Database) at two IT cluster sites. The remaining four sites are projected to be live by early 2016. Both Sheriff Medical Services Bureau and the Juvenile Court Health Services also use a Cerner product EHR. Cerner Hub, a tool that facilitates information sharing between Cerner systems, will be live and able to begin linking the Sheriff, Probation, and DHS systems by fall 2015.
- DMH is mid-way through its implementation of Netsmart's IBHIS product, it has implemented approximately 100 of 138 directly-operated sites and four contracted sites. Netsmart is a niche mental health product, capable of performing clinical documentation and claims/authorization functions required to fulfill DMH's role as the Medi-Cal Local Plan Administrator for specialty mental health, serving contracted legal entity providers and providers in the Fee for Service Medi-Cal network. DMH will soon pilot use of Netsmart's Care Connect module that exchanges referral information and continuity of care documents between participating systems, including those not using Netsmart products. These steps can enhance care coordination, but are not optimal solutions for managing shared clients/consumers/patients.

- DPH has been working with DHS since 2014 to explore the feasibility of adopting ORCHID as the EHR for its fourteen Public Health clinics, leveraging the County's contract with Cerner that was specifically written to facilitate the addition of additional County departments at the same preferred pricing level available to DHS. In February of 2015, DPH met with DHS and Cerner to explore DPH's business requirements and identify potential system gaps. There were no significant gaps identified that would prevent adoption of the ORCHID platform for clinical services. The Departments are working to resolve several technical and operational/design issues before finalizing a contract.

Despite the advantages of being on a shared EHR, given where DHS and DMH are in their respective implementations, it would not be prudent to disrupt either's ongoing implementation. The consequences of changing course would be expensive, and possibly hugely damaging to programs, services, client/consumer/patient confidence, and the good will of the County's contracted providers. If a diligent investigation into the advantages and disadvantages of converting to a single shared EHR confirms such a move is in the best interests of the County and its consumers, the transition would take several years to implement.

Even if the County does someday shift to a single EHR solution, this would not directly address the need for information exchange with contracted community-based providers, each with their own EHRs. To better integrate services for those who receive care outside of directly-operated County clinics, the County must continue its support for LANES (Los Angeles Network for Enhanced Services), the organization implementing a Health Information Exchange (HIE) collaboration between LA County stakeholders including the Community Clinic Association of Los Angeles County, LA Care Health Plan, and the Hospital Association of Southern California. The County must also develop an Enterprise Master Patient Index (EMPI) which can reconcile multiple unique identifiers used for the same patient and help ensure the correct patient is identified. Progress on this initiative is ongoing and should continue, regardless of the ultimate decision concerning the creation of an agency. As important as it is, an EMPI is not a perfect substitute for a true single identifier which is not subject to the same errors as an EMPI and can support more complete information exchange.

Beyond the potential for a single or linked EHR, there are additional opportunities to leverage IT in a way that could enhance departmental operations, improve service levels, and reduce costs.

Applications (outside of the EHR): The three Departments currently use many different systems for a variety of common functions. The Departments could evaluate their collective library of applications to identify opportunities to consolidate currently unlike systems, with resulting cost reductions and improved alignment of processes, data, and reporting capabilities. Examples of areas to investigate include physician credentialing/master provider database, pharmacy benefit management, health care claims clearinghouses, referral management systems, active directory, and Picture Archiving and Communication Systems (PACS) that facilitate the movement of radiological studies across clinical environments. As longer term opportunities, the Departments could consider an aligned approach to Personal Health Records, allowing individuals to utilize the same system for accessing personal health information across Departments. They could also consider a coordinated strategy to billing and cost-accounting systems. The Departments also each use several IT applications that are unique to the functions of their Department and would not be appropriate for convergence. These individual applications should continue to be supported regardless of work on shared applications.

Data Governance and Repositories: If DHS, DMH, and DPH are to effectively coordinate care and improve service delivery, there must be agreement on the meaning of data used across Departments; this is achieved through a process known as data governance. A joint data governance approach would lay the foundation for more effective use of data to meet County goals. There would also be significant value to the County of the Departments having a single health care data warehouse. Both DHS and DMH have invested in their respective data warehouse/repositories to address the much broader range of data becoming available with the implementation of their EHRs. DPH does not have a data warehouse or

data analytic infrastructure but could establish data feeds into DHS' repository and build a Public Health data mart if it determines there would be value in building data reporting and analytic capabilities. Making these investments by leveraging existing infrastructure would be more cost-effective than making de novo investments alone. As with EHRs, data repositories can be structured to properly safeguard data privacy and security. If shared data repositories are developed, DPH, DHS and DMH will need to work with County Counsel to examine consent and data use guidelines to ensure compliance with all regulatory requirements.

Improving use of space and facility planning to improve access and reduce costs

As described in greater detail above, one important way in which services can be integrated at the point of care is through co-location. Co-location may have several advantages:

- It may offer individuals more choice in terms of where they receive care, allowing people to attend the type of facility or clinic in which they are most comfortable, expanding access to care and retention in care.
- If it is designed in a way that improves geographic access, this can result in improved customer experience and improved geographic coverage for managed care contracts.
- If a portion of clinical (e.g., nursing attendant, substance abuse counselor) or support staff (e.g., front desk staff, security) are shared, it can reduce administrative costs
- It may provide an opportunity to diminish the stigma associated with the provision of mental health services - if the culture and service delivery provided by health facilities is embracing of those with mental illness.

Beyond the co-location of clinical services, an agency presents an opportunity to more effectively manage the County's inventory of county-owned and leased facilities, including clinical, administrative, and warehouse buildings. Each of the Departments currently faces several challenges with respect to their facilities. All three face capacity constraints and are looking to expand services in specific geographies. Each Department has several old County-owned buildings which have major deferred maintenance needs and will require substantial capital investment in order to provide safe and efficient work environments. Further, many buildings are not designed in a way that supports current operations and services. By managing space jointly at the agency level, the County could be more strategic in how it uses space, where it chooses to buy or lease new buildings, helping the County to avoid additional capital investments in new infrastructure. In thinking through specific space-related opportunities, it is important to keep in mind the different ways each Department conducts its business, unique regulatory requirements (e.g., OSHPD or Cal-OSHA) that must be met, the role of field-based staff, ADA accessibility, and the availability of parking, public transportation and support infrastructure.

Improving ancillary and administrative services and functions

Greater efficiencies in ancillary and administrative areas can improve service quality, an individual's experience interacting with the system, and, by reducing duplication and producing economies of scale, can reduce cost, allowing funds to be redirected to clinical and population health programs. Considered briefly here are opportunities in pharmacy and non-pharmacy ancillaries (e.g., radiology), contracting/purchasing, and human resources.

<u>Pharmacy and non-pharmacy ancillaries</u>

There are several potential opportunities to improve pharmacy services under an agency model. The first is related to ways of enhancing pharmacy access. DMH uninsured clients could be extended access to DHS pharmacies. This may also result

in savings since the DHS cost to refill a prescription is less than the fee paid to DMH's contracted pharmacies. Additionally, individuals seen at both DMH and DPH could potentially receive prescription refills by mail using DHS' Central Fill location.

Second, the Departments could benefit from implementation of an evidence-based unified drug formulary and prescribing protocols/practices. This would provide individuals with a more consistent experience across County facilities and would reduce costs by increasing the use of generic medications and consolidating use on a smaller number of pharmaceuticals. DMH conforms its indigent formulary to the Medicaid formulary to prevent dual levels of care between insured and indigent clients. However, there may be savings possible by adopting different formulary practices; typical savings from such moves are 10-20% of non-reimbursed annual pharmacy expenditure.

It may be possible to extend 340B pharmaceutical pricing to DMH's directly-operated clinics, typically accessing such pricing through DHS facilities' covered entity status. DHS hospitals and DPH clinics have access to 340B pricing already. It is not advisable to attempt to extend 340B pricing to contracted clinics given that it would require substantial disruption to existing service patterns. While there are several ways in which DMH's clinics may gain access to 340B pricing[25], it would be a long-term process, would require substantial administrative restructuring of DMH facilities and regulatory approvals, and would possibly impose new risks to DHS as the covered entity responsible for oversight and audit of the 340B program. The County should carefully investigate the estimated financial savings (currently estimated at $2-3 million annually) and operational impact before embarking on this path.

Adopting a single or at least coordinated strategy for ancillary clinical and operational services outside of pharmacy can benefit clients/consumers/patients by improving service quality and helping to realize operational efficiencies and financial savings. Such efforts could be applied to clinical laboratory services, radiology, durable medical equipment, employee health services, home health services, and medical transportation. As an example, DPH currently provides a small amount of radiology professional services through a contract radiologist. DHS, with its larger radiology practices, may be able to provide this service for the same or lower cost and with fewer service interruptions. Also, DMH processes labs collected within its directly operated clinics at contract, non-County labs. Given the highly automated nature of most laboratory test processing, a DHS or the DPH lab could provide the same processing at a net county savings.

Contracting, contract monitoring, and purchasing

In stakeholder sessions, some external entities who contract with multiple Departments shared hope that an agency would be able to reduce unnecessary duplication such as with auditing, reporting, and contract monitoring practices. They expressed a desire for an aligned and accelerated contracting approach which took into account the full breadth of services purchased. As one client put it "If the agency's only achievement was a single, coordinated RFP, reporting, and audit process for each of the three Departments, it would be worth it just for that." Other ways the Departments could work together include 1) Developing future contract solicitations that could be used by any of the three Departments. 2) Consolidating similar contracts if programmatic alignment is strong and services are not tied to restricted dollars (e.g., MHSA). IT contracts are one area that may benefit given the specialized contracting expertise needed. 3) Expanding best practices across the Departments, including pursuing greater flexibility when contracting for proprietary services (e.g., maintenance contracts). 4) Exploring master agreements with similar terms and conditions but with options for different scopes of work and funding caps.

[25] Four models for extending DMH 340B pricing: 1) Merged Location: DMH clinics and staff must be fully merged with and physically located within the "four walls" of a registered 340B hospital. 2) Child Site: Covered entities add "child site" locations (outpatient facilities located outside the four walls of the covered entity, subject to geographical limitations on distance between facilities). 3) Referral Relationship: A DHS hospital refers 340B-eligible patients, as needed, to DMH clinics for mental health treatment. The covered entity retains responsibility for the overall care of the referred patient and use of any 340B drugs dispensed. 4) FQHC Look-alike Status: FQHC "Look Alikes" are eligible for 340b pricing but must meet federal regulatory requirements under Section 330 of Public Health Law, including the need to have a governing board made up of individuals currently being served by the health center.

Changes should be made with caution to avoid unexpected adverse effects. As one contractor put it "From my perspective, things are fine. I've figured out how to navigate County ways. There may be advantages to the County of doing this, I don't know, but please don't let the agency make things worse for us."

Contract monitoring and program audits may also benefit from greater collaboration, for example by having contract monitors or program auditors assigned to administrative/insurance compliance for shared contractors across the agency. An in-depth review would highlight what agreements may benefit from shared monitoring functions and which may require specialized knowledge or skill sets to ensure compliance. Given that each Department raised concern about an inadequacy of resources for contract monitoring, moves to streamline contracting activities would help to make good use of scarce resources and free up staff to focus on audit functions.

Given the different state of each Department in their eCAPS roll-out and the different manner eCAPS is used to meet their organization's procurement needs, it would not be advisable to consolidate the Departments' purchasing functions at this time. There are opportunities, however, to optimize purchasing practices, such as by fully capturing manufacturer rebates and other cost saving mechanisms, extending use of University Health System Consortium (UHC) Novation Agreements[26], and sharing warehouse space and supply distribution infrastructure. The County also has the opportunity to leverage better pricing and standardized support through an enterprise approach to IT purchasing and contracting. Where the three Departments utilize common products or services, there is an opportunity to establish master or joint agreements that could be leveraged by each.

Human Resources (HR)

Creation of an agency could help improve HR operations and enhance consistency in several ways:

Exam planning and development: DMH, DPH and DHS utilize a number of the same or similar classifications where exam planning and administration is delegated to the Department-level. At present, collaboration is limited to requests to use an eligible list that resulted from another Department's exam. An integrated approach to exam administration for common classifications could result in better exam planning and recruitment outreach and more efficient use of subject matter expertise and HR analysts, though this may not be appropriate for all classifications. For example, an agency could seek delegated authority from DHR to run exams for County-wide classifications (e.g., IT positions) for all three Departments, tailored to the specialized needs of health-related departments, while still coordinating with DHR on all master calendar exams. More broadly, an agency would be strategically positioned to develop classifications and job specifications closely tied to health care delivery. As an alternative view, some felt greater coordination on exams could result in worse outcomes for individual Departments (e.g., longer planning period; inability to attract appropriate staff, etc.).

Employee relations and risk management: There is significant overlap among staff classifications at DMH, DPH and DHS. Consequently, the three Departments interact with many of the same unions via labor-management committees at the Department and County levels. Strategy-setting and engagement at the agency level would enhance each Department's ability to manage issues related to commonly represented classifications, employees, and functions. For instance, an agency initiative to engage represented employees in working to the top of clinical license would have greater impact than each Department pursuing separate strategies in union engagement.

Following are some additional examples of areas where greater collaboration would yield benefit on staff-related issues:

[26] UHC is a national healthcare consortium that competitively solicits bids for goods and services to leverage volume purchases to achieve low pricing and rebates to customers for future UHC purchases. DHS currently uses UHC for medical equipment and supply purchases. DPH indicates they currently use UHC only for certain medical commodities. DMH does not utilize UHC.

- DHS is adopting Safe and Just Culture principles to improve clinical operations, risk management and performance management and could be scaled to include DMH and DPH.
- Departments could better align in how they manage performance improvement initiatives, including mechanisms for engaging front-line staff, middle-management and labor colleagues.
- Departmental approaches to employee wellness could be jointly pursued such as those exemplified by DPH.
- An agency might create greater opportunity to investigate and, when appropriate, advocate for a solution to classification-compensation issues, such as pay discrepancies between similar classes.
- DHS and DPH might implement a Staff Advisory Committee in the manner that DMH has done.

Maximizing revenue generation

In an agency model, there may be opportunities to generate additional revenue through more collaborative and integrated efforts between the three Departments. Following is a summary of potential opportunities. Each of these would need to be further evaluated before a definitive decision could be made as to the magnitude of the net benefit that could be achieved and the timeline over which each opportunity could be pursued.

Managed care contracting and billing: Managed care revenue contracting is in its infancy in the County outside of DMH's status as the Medi-Cal specialty mental health (SMH) plan under California's carve-out for SMH services in which it has responsibility for Medi-Cal clients with serious mental illness (SMI). In fulfilling this responsibility, DMH both contracts for and directly operates clinics providing the required services and also maintains a contract to provide SMH services to all plans participating in Cal Medi-Connect serving those who are dually eligible for both Medicare and Medi-Cal. Clients with mild to moderate mental illness (i.e., non-specialty mental health [NSMH] services) are managed through Medi-Cal's managed care two-plan model in LA County or through fee-for-service (FFS) Medi-Cal. DMH is beginning to consider developing contracts outside of the scope of the SMH carve-out, investigating opportunities to execute Medi-Cal contracts to provide treatment for NSMH services and for treatment of SMI for non-Medi-Cal/non-indigent individuals. DHS holds two contracts with Medicaid managed care plans and eighteen contracts with other health plans, independent physician associations (IPAs), hospitals, and pharmacy benefits management companies, with one more in progress. At present, DPH's Substance Abuse Prevention and Control (SAPC) program provides services to behavioral health affiliates, LA Care, Health Net, and Molina, through its MOU with Care 1st and its agent Beacon Health Strategies. Substance Use Disorder (SUD) services are provided to these managed care plan participants that qualify and SUD services are reimbursed through the Drug Medi-Cal program. At present, DPH bills Medi-Cal for immunizations and is in the process of billing for TB Directly Observed Therapy (DOT), along with a pilot for public health nurse Targeted Case Management. .

In the nearer term, while all three Departments bill private providers to different extents (e.g., DMH bills Kaiser and other health plans for emergency services), opportunities remain to further support revenue generation through billing. While DPH has tried to utilize DHS billing infrastructure in the past, DHS was unable to provide immediate support at that time given the simultaneous changes in organization and infrastructure of its billing systems. A renewed collaborative between the Departments could facilitate DPH's ability to contract with the health plans and providers and then claim for TB and other clinical services, such as Sexually Transmitted Disease (STD) care. For example, DPH is developing a platform off the SAPC-based Medi-Cal claiming translator to bill for DOT services. Other counties have leveraged their ability to bill Medi-Cal for DOT to contract with and bill private providers (e.g., a commercial health plan such as Kaiser) for public health services that otherwise would not receive any reimbursement. Ventura County DPH also has a contract with Kaiser to bill for its services. As another example, the County could build off of DMH's contract to provide e-Consult psychiatrist services by offering both additional e-Consult services available within DHS and also offering DMH's e-Consult services through DHS' contracts with other health plans and/or their contracted providers.

Over the longer-term, bigger opportunities exist. The County has a large potential to increase the depth and breadth of managed care contracts with health plans and IPAs, particularly if it is able to market an integrated model of care. The County's efforts to attract and retain revenue-generating individuals will be critical to the future competitiveness and financial viability of the County's health Departments and its ability to fulfill its Section 17000 responsibilities without infusion of additional revenue. While the Departments are exploring ways to expand managed care contracts for their respective services, pursuing these arrangements within a highly integrated model of care that includes a full spectrum of mental health (mild to severe), physical health, substance abuse, and select public health services, could be more attractive to individuals and plans alike. This type of service offering might be particularly attractive to plans if it targets known high-utilizers or particularly complex (clinically and socially) or vulnerable populations that the County has a unique ability to serve and that private providers may not want to see. An agency could build a model to serve these people by combining the health offerings of the three Departments into one package, supplemented by social services available in other County departments. Integrating safety net services offered by these Departments would give the County greater expertise in handling more acute patients with multiple diagnoses and social issues, a benefit that could be leveraged to negotiate higher reimbursement rates.

Some stakeholders felt that such opportunities for greater managed care contracting were speculative at best. They pointed to DHS' history of losing market share among obstetric patients to community Medi-Cal providers in the 1990s and continued challenges in attracting large numbers of non-high risk obstetric patients to the County. They also commented that the competitive challenges in the current Los Angeles health care marketplace were not taken into account and might make these managed care opportunities difficult to achieve. Finally, there is the danger that a health plan may be interested in only purchasing part but not all of the services offered.

Over time, the County may decide to enter into novel financing arrangements which would give the County greater flexibility in funding services and programs that currently have no available revenue stream. As an example, the County may wish to enter into risk-sharing relationships with the State and health plans in which it assumes full responsibility for the comprehensive provision of health services, including physical and behavioral health, by directing funds for SMH, SUD, and physical health services into a single capitated payment, although state law changes and federal approval would likely be required if Medi-Cal beneficiaries are to be involved. This type of financial integration would be an added support for clinical and service integration initiatives. While these opportunities are being pursued, it will be important to not disrupt existing strong relationships between plans and the County. For example, one health plan indicated that its relationship with DMH for referral of SMH services is "a model for the entire state." The County should strive to preserve these relationships as it considers implementing or shifting to consolidated contracting arrangements.

Prior to considering a consolidated contract with health plans to cover physical, mental, and specialized public health services, the County would need to consult with the State Department of Managed Health Care to determine if a full Knox-Keene health plan license is needed. DHS is in the process of converting its existing license to a restricted Knox-Keene license as a result of the wind down of the Community Health Plan. If a plan license is required to allow the agency to do comprehensive contracting for the services of all three Departments, the agency model would have to take into consideration the organization and composition of the entity subject to licensure, with implications on maintenance of financial records, performance of audits, etc.

Supplemental Medi-Cal Managed Care payments: For the last several years, DHS has been able to receive supplemental payments from Medi-Cal managed care plans using intergovernmental transfers (IGTs) to fund the non-federal share of increased capitation payments to the managed care plans, which then pass the money on to DHS. DHS cannot presently access all of the supplemental revenue that can be created through IGTs. It may be possible for DMH or DPH also to receive payment from Medi-Cal managed care plans using IGTs, as long as they can provide non-administrative services of benefit to the plans. Ideas for such services include immunization and STD care through DPH, or enhanced case coordination/case

management service for those mentally ill individuals that shift between moderate and SMH care during the course of their illness. Implementation of such initiatives will require the approval of both the State and CMS. Given that there is a capped amount of supplemental Medi-Cal managed care revenue that can be IGT-funded, an agency model could help assure that each Department gets access to an appropriate share of these funds.

Skilled Nursing and Institutions for Mental Disease (IMD) Beds: DMH currently utilizes about 840 IMD beds to provide residential treatment for individuals who might otherwise require prolonged acute hospitalization. Presently, DMH buys all available beds in LA County and has even bought beds in neighboring counties. Medi-Cal will generally not pay for services in an IMD, and IMD beds do not have a dedicated revenue source. However, Medi-Cal will pay for skilled nursing/IMD-level services in facilities that are not predominantly providers of mental health care. Thus, combining skilled nursing care for physical health problems with a lesser amount of IMD type services in the same facility allows Medi-Cal funding for both types of care. By leveraging DHS' and health plans' needs for services in a combined facility, it may be possible to expand DMH's current practice of using SNFs to augment IMD level of care. Another possible way to bring in federal dollars for IMD-level services which may merit further exploration involves bringing them within the scope of the more general managed care obligations of the health plans.

Cost-Based Reimbursement Clinics (CBRC) Revenue for Public Health Clinics: An agency could evaluate the feasibility of obtaining CBRC revenue (a special Medi-Cal payment program that provides full cost reimbursement for outpatient services in DHS) for certain public health services, such as immunizations, STD testing, and women's health. Under current rules, CBRC is not available for specialty mental health services or for services in clinics which provide predominantly public health services, but public health services could be eligible for CBRC if they were incorporated more fully into DHS clinics. Certain public health functions, such as Targeted Case Management (TCM) and Medicaid Administrative Activities (MAA) are already receiving partial Medi-Cal reimbursement through MAA and TCM programs. Careful analysis would need to be done to ensure that CBRC revenue would be superior to other revenue streams currently available to DPH for TCM and MAA programs. Analysis should also ensure that an appropriate mix and type of services are moved to DHS site, considering geographic access, space/renovation needs to accommodate specific clinical conditions (e.g., TB), and impact on DPH clinics' designation as Essential Service Providers (ESP) under Covered California.

Patient Financial Services (PFS) Reimbursement: DHS employs Patient Financial Services (PFS) workers to take Medi-Cal applications from patients and bills for and receives offsetting Medi-Cal administrative revenue of about $15 million per year. Under an MOU with the State, such DHS employees assist with application completion and data entry, make a preliminary eligibility determination which is confirmed by DPSS. DMH PFS/Eligibility Workers (EWs) assist clients with Medi-Cal applications but rely on DPSS staff to complete the eligibility process and thus do not receive administrative reimbursement. DPH does not employ EWs because it does not currently bill Medi-Cal as it is implementing its financial screening and billing process to comply with Title 22 requirements. DPH is actively engaged in developing processes to bill for certain services. If that is successful, it may be appropriate for DPH to employ EWs to help with identifying and accessing coverage by third party payers. The County may also be able to extend DMH and DPH access to the current MOU with the State, expanding funding for enhanced Medi-Cal eligibility activities.

Hospital Presumptive Eligibility (HPE): DHS is currently processing applications at its hospital locations for Medi-Cal HPE, which is a program providing full-scope Medi-Cal benefits for a short period of time to allow an ordinary Medi-Cal application to be taken and processed. DHS is evaluating ways to extend HPE to its outpatient clinics using hospital staff and could potentially extend this to DMH and DPH sites. There are certain advantages of to obtaining short-term Medi-Cal coverage in higher cost hospital and clinic settings. Given that it may preclude use of HPE for higher cost services that occur later in the same 12-month period, it may not be beneficial to the County to extend HPE to all sites within DMH and DPH. However, use of HPE at some DMH and DPH sites would help additional individuals enroll in Medi-Cal and could provide a

temporary revenue source for those that might not visit a DHS facility. This issue should be evaluated more fully before implementation begins.

Improving workforce education and training

A wonderful strength of the County health system is its rich and talented workforce. Through the direct actions taken by the agency and the indirect effects of the agency's effort to integrate care, an agency can support workforce education and training in ways that build staff capabilities, increase workforce satisfaction, and enhance recruitment and retention. Innovation in clinical service delivery and population health will not be successful without workforce education. Best or expected practices in workforce education could be established across the agency and shared with each Department. Performance/quality improvement programs should be commonplace. Developing shared approaches and tools for improving performance on new or existing initiatives will help the County to efficiently alter programs, approaches, and front-line practices.[27] In some cases, expanded roles or the creation of new/broader classifications may be needed, helping to diversify the workforce, support job ladders and create promotional opportunities. These in turn might help invigorate the County's workforce, with benefit for both those served and employed by the County. Finally, classifications that are currently underutilized within the County might find greater use if programs and duties were planned and structured in a coordinated way.

Workforce education opportunities can be increased with minimal investment simply by better leveraging the unique strengths and expertise already available in each Department. As an example, DMH could provide de-escalation training to some DPH and DHS staff. In other areas, new investments may need to be made, but doing so across all three Departments would be a more efficient use of available resources. For example, the County could benefit from potentially creating a County-wide Community Health Worker (CHW) institute that would support both County and community-based CHW efforts. Also, each Department is involved in customer-service training initiatives for front-line staff. While the services may be disparate, the intended customer (the public, client, consumer, patient) may be interacting with more than one Department. A common approach to basic customer service would enhance the customer experience and likely lead to efficiencies in training resources over time.

An agency can also prioritize consistency in training and practice among staff with similar job functions in each Department. Such cross training may allow certain staff in one Department to find new and energizing opportunities within another. As an example, care models might evolve so DHS patients might receive home and community based care services from staff and programs operated by DMH or DPH staff. Also, the majority of DMH and DPH services do not operate 24/7. Cross-training staff to support "after hours" coverage of vital services that don't currently operate 24/7 could help improve access and also energize staff by exposing them to new, valuable roles within the County.

Strengthening the County's influence on health policy issues

Due to its sheer size, LA County has a very visible role in shaping state and federal policy. However, efforts are often poorly aligned because the three Departments approach advocacy and policy differently. Under an agency model, policy and advocacy priorities could be set and advanced together. The stories of front line experience can be complimented by broader, population-focused data and trends. As one public health leader said, "we [DPH] would benefit by having DHS or

[27] Although the nature of the process improvement work across Departments may differ, the approaches may be similar and done in an integrated manner. Care should be taken, however, not to eliminate important differences between Departmental approaches.

DMH by our side when we are talking to city councils about an issue in their community because our sister Departments can tell the real life stories about patients who might be impacted by the areas we discuss."

At this moment in time, there are some obvious areas where a collective policy and advocacy agenda and approach would be applied. The current drug Medi-Cal provider certification process is being developed by the State; LA County has much to gain or lose depending on the direction the State takes. There is also ongoing conversation more locally about the built environment (e.g., parks, neighborhood design) and community development. Finally, a policy agency could include advocacy to rationalize the various financial incentives and financing streams that are often a barrier to greater service integration. In any of these instances, a louder and cohesive voice from the County's health agency could be more effective than DPH, DHS or DMH moving forward alone. An agency should be cautious to ensure that a joint approach to policy and advocacy prioritizes issues of importance to each Department, rather than solely focusing on those issues that are of concern across multiple areas.

Aligning resources and programs to reduce health disparities

The ultimate goal of the County's health-related Departments is to improve the health and well-being of all LA County residents, promoting equity for all and not just for a fortunate few, enhancing parity of access to care and services across physical, behavioral, and population health. Accelerating progress toward these goals will help address the disparities that exist among many segments of LA County. As an organizational structure, the agency can more effectively raise visibility into the unmet need of particular populations and identify interventions that will help to address gaps in care than any of the three Departments would be able to do alone. To be successful in achieving this, the agency must focus on providing culturally and linguistically competent care in all its domains. As with most characteristics, each Department possesses this in pockets but it has failed to permeate completely through any Department. The agency could play a strong role in spreading the lessons and practices of those areas that perform well in this regard. This will need to involve the active involvement of external stakeholders who can quickly point out gaps in care and can provide early and objective notice of populations not benefiting from departmental programs.

A variety of factors, many of which are mutable, contribute to health disparities: variable coverage for and access to services, the stigma of certain medical conditions, disjointed care delivery systems, inadequate or ineffective public messages, cultural and linguistic barriers, and a lack of attention to enabling resources including transportation, food, housing and education/job training. While DPH has made significant progress in drawing attention to these issues through their work with other Departments and their data briefs on these issues, more unified leadership and priority setting could advance achievements in addressing these factors. These include creating a more effective way for County and community partners to guide investment by the local, state and federal philanthropic community. DPH currently provides information and data analysis about cross-over disparities (i.e., food or transportation access) and disparity "hot spots" in the County.[28]

In regards to stigma amelioration, service integration can help to reduce the impact of stigma of mental illness and substance abuse by providing individuals with more choice as to where they access needed services. An aligned approach can also more strategically connect public health awareness and prevention messaging to care delivery environments. Disparities are in part driven by the paradigm that has long separated components of health when the actual experience of the person who has needs in more than one health area is whole or un-separated. As one stakeholder said, "under a consolidated approach, LA County might become a leader in addressing health disparities and creating an effective bridge between what happens in the communities, in families and what happens in the more intimate service settings."

[28] These are accessible online through LA HealthDataNow! (https://dqs.publichealth.lacounty.gov/), the DPH Health Viewer (http://publichealth.lacounty.gov/epi/HealthViewer.htm), and through posted reports.

Drawbacks and Risks of the Agency Model

In soliciting input on this report, many stakeholders were openly critical of the Board motion and the lack of public discussion before the item was placed on the agenda. Individuals described feeling "violated", "ignored", "offended", "blindsided." Stakeholders often commented that the County had "betrayed their trust," and made it difficult for them to engage in a full discussion of the agency. This sentiment can only be addressed over time, by establishing transparent processes related to creation of an agency and maintaining open communication with stakeholders over time, including after the time at which this report is submitted to the Board.

Beyond extreme displeasure with the technical process, stakeholders raised a number of specific risks with respect to the agency model. The text below provides a summary of these risks. In some cases, the risks had been specifically recognized in the Board's resolution supporting in concept the creation of an agency instead of considering the possibility of a single department. Some of the objections raised by stakeholders would be much more germane if the model were a combined department. Under an agency model, the legal and HR-related concerns raised by stakeholders would not come to pass; similarly, it would not be possible under an agency model for an agency director[29] to cut Departmental budgets without Board approval. As a result, the discussion of these risks is appropriately brief.

The risks that are included in this section are listed below.

1. Potential legal risks
2. Potential human resource risks
3. Risk of history repeating itself: Feared service/budget cuts and deprioritization of County functions
4. Risk of additional layers of government bureaucracy
5. Risk that agency will require financial investment for administrative positions
6. Risk that Departments will lose focus on the full breadth of their current missions
7. Risk that cultural differences will compromise integration efforts
8. Risk of medicalization of community-based mental health
9. Risk of disrupting existing service models and the staffing structures and partnerships they rely on
10. Risk agency planning will distract from the work of service integration

Potential legal risks

County Counsel reviewed potential legal risks associated with the agency model and did not identify any legal impediments. They did, however, raise several issues that will need to be monitored should the Board move forward with creating an agency.

1. The Director of Health Services (which is interchangeable under the Charter and County Code with the Director of Hospitals), the Director of Mental Health, the Director of Public Health and the Health Officer are all positions to be appointed by the Board, in accordance with qualifications and requirements set forth in California law and the County Charter. However, nothing precludes these positions from being included within the agency structure. Traditionally, the Board has been the final, appointing authority in the event of a vacancy in any of these positions.

[29] Throughout this report the term "director" is used for the individual who leads the agency. If an agency is created, the Board should consider the best title for this role. While "director" is common, it may be confusing given it is also used to refer to Department heads. Other alternatives include secretary, executive officer, etc.

2. At this time, no reduction, closure or elimination of medical services are expected such that the Beilenson hearing process would be triggered. As agency priorities are set and integration activities accelerate, the agency will need to work closely with County Counsel to monitor the applicability of the Beilenson hearing process if medical services are realigned or relocated.
3. The implementation of an agency structure does not threaten the reimbursement each Department receives. While some funding is necessarily restricted by operation of law or agreements with funding agencies, such as certain mental health funds and public health related grants, or requires the contribution of a match or maintenance of effort, as long as those restrictions are honored, no legal impediments based on revenue and reimbursement should exist. As stated previously, the proposed agency will preserve existing budgets and funding streams of each Department.
4. As previously discussed, the County has the potential to negotiate a consolidated contract with health plans to cover the provision of physical (both physician and hospital cost components), mental health and specialized public health services, such as directly observed therapy for TB patients. County Counsel and departmental representatives will need to consult with the State Department of Managed Health Care (SDMHC) to determine if full Knox Keene health plan licensure is needed as a prerequisite to the County participating in this kind of contractual arrangement. As the Board may be aware, DHS is in the process of converting its Knox Keene license to a restricted license as the result of winding down the Community Health Plan. If a plan license is required, the agency will have the ability, through a request for a material modification to SDMHC, to request the restricted license be expanded to a full license. The agency would have to take into consideration the organization and composition of the agency and the concomitant implications on maintenance of financial records, the performance of audits and such other aspects to ensure compliance with SDMHC's legal and regulatory requirements.
5. DPH currently must audit and/or provide program oversight functions for Public Health-funded services provided by DMH and DHS (e.g., services funded by Children's Medical Services and Division of HIV and STD Programs). Creation of an agency model can be achieved without compromising DPH's role. To avoid any perceived conflict or appearance of impropriety, a separate audit division can be created or maintained from the programs that will be subject to audit. Thus, staff that are responsible for program implementation would not be vested with auditing that function.

Potential human resource risks

The Department of Human Resources, CEO Classification/Compensation, and CEO Employee Relations did not identify any direct risks of creating a health agency. Some County staff were apprehensive that the very act of creating an agency and appointing an agency director would have direct consequences on classification, compensation, and employee relations (ER) issues. Despite assurances that the agency would not bring about layoffs or service cuts, some staff also felt unsure about how an agency will affect their work assignments and roles. Specific questions raised are included below.

- Will the creation of an agency result in lay-offs or staffing reductions?
    - No. Creation of an agency would have no impact on Departmental budget appropriations or staff; there would not be lay-offs as a result of the agency being created. The agency's goal is to improve and enhance services and programs across all three Departments; budgetary or staffing reductions are not consistent with this goal.
- Will the creation of a new "agency director" item lead to the automatic downgrade of positions in the three Departments?
    - No. The positions within each Department would continue as they are today. If the Board chooses to create an agency director position, it would not automatically downgrade roles in the County.

- Will an agency model affect the depth or number of unclassified positions in each Department?
    - No. The three levels of unclassified positions allowed in the Charter can be maintained. The County charter states, "In each County agency and department: The positions, if any, of Chief Deputies, and of assistants or deputies next in line of authority to Chief Deputies" are unclassified. As long as departments remain under the umbrella of an agency, then a department head and the levels stated above would remain unclassified.
- Will the County be required to reconcile differences in HR and ER-related issues affecting employees of the same or similar classifications (e.g., pay differentials, differences in MOUs with labor unions, etc.)?
    - No. Where differences exist, they are based on differences in employee roles, responsibilities, or working conditions. The creation of an agency will not automatically force these differences to be reconciled. Based upon current case law, the County will be required to review differences if the agency has an impact on wages, hours or working conditions for any impacted classification. If there is no direct impact on wages, hours or working conditions, the County would only address these differences during MOU negotiations as needed. However, the agency could create a forum for better understanding the reasons for these differences and, when appropriate, advocate for a proper resolution.
- Will the agency affect seniority pool as used, for example, to determine vacations?
    - No. At the management or executive levels, the concept of "seniority" is not applicable. This construct applies mainly to labor-represented classifications. SEIU Local 721 health-related MOU's contain vacation scheduling provisions. There cannot be a change in the process without renegotiating these MOU provisions. We would expect Non-SEIU classifications (e.g., physicians) to continue vacation scheduling as is the current practice. Other uses of seniority would also not be expected to change.
- If a reduction in positions within one Department were to become necessary, would this trigger a cascade in staff re-assignments across the agency to remain consistent with County seniority rules?
    - No. Cascades are typically handled within the department having the budgetary issues necessitating the workforce reduction. If not able to be managed within the department, the cascade is managed at the County level, including all Departments with like items. This would remain the case under an agency model. Position reductions, while rare, have virtually always been able to be accommodated by filling vacant like items. Every effort would be made to re-assign displaced staff within like classifications. The creation of an agency would have no effect on these practices as these activities would be coordinated by the involved Department(s) and the Department of Human Resources in accordance with existing civil service rules, MOU provisions, and/or Board Policies.
- How will the agency affect roles and responsibilities of specific positions, geographic assignment, scope of practice, and team structure?
    - The creation of the agency itself will not affect any of these issues. As integration progresses, the agency and Departments will need to communicate openly with staff and organized labor about ways in which job responsibilities may be affected. As noted above, if initiatives or program changes would affect wages, hours, or working conditions or impacted classifications, they would be the subject of formal consultation with organized labor.

Risk of history repeating itself: Feared service/budget cuts and deprioritization of County functions

When the Department of Mental Health was merged into a single Department of Health Services, along with the Department of Public Health, in 1972, it ushered in six challenging years before DMH was split out again in 1978. Funds were directed to urgent or emergent needs in the hospitals, even though some of the funds were supposed to be dedicated to mental health. Leadership gaps and a geographic operating model further complicated the single department's

operations and contributed to the eventual separation. In the 1990s and 2000s, the Department of Health Services, which was then made up of separate divisions of public health and hospital/clinic care faced financial deficits and went through a series of budget cuts. While the cuts were distributed across the department they also included cuts to important population health programs. Population health advocates and some DPH staff who lived through these years perceived this as a cannibalization of public health's budget. These budgetary concerns and the distinct missions of the public health and hospitals/clinics arms of the Department were major reasons behind the split of DHS into two separate departments, DHS and DPH, in 2006.

Many people raised concern that creating an agency would be asking for history to repeat itself. As one stakeholder asked "If it didn't work in 1972 and it didn't work in the 2000s, why would it work now?" While not the exclusive focus, concern was often centered on preservation of Proposition 63 Mental Health Services Act (MHSA) dollars made possible by victory in a hard-fought 2004 ballot initiative. MHSA funds form the foundation of numerous mental health programs and services for clients across the County, including funds for prevention and early intervention, services, and infrastructure, including technology and training, and are rightfully protected by mental health advocates. Some stakeholders commented that despite the safeguards that protect the use of MHSA funds for mental health programs, they worry that an agency would lead to the gradual diversion of funds for non-intended uses. Many people pointed to the DHS' budget as the likely target of such funds, dominated by hospitals with large fixed costs and with an industry known for acute/emergent problems. While many stakeholders were not aware of DHS' current fiscal surplus, even those that were aware expressed concern of money being taken from DMH (or DPH) to fund DHS if its fiscal outlook worsens in the future. One population health advocate voiced, "Clinical imperatives always trump public health. The urgency of 'now' trumps long-term benefits."

Cuts to a Department's budget are not possible in an agency structure without Board approval. Cuts to mental health in the 1970s and to public health in the early 2000s were perceived as possible without Board approval because of the organizational structure in place at the time of a single merged department. Department heads have the authority to recommend the movement of funds within their Department, but ultimately, all changes between Department budget units must be approved by the Board of Supervisors. Because the agency model preserves the structure of the three separate Departments, it would further highlight any budgetary shifts between Departments. If a situation arose in the future in which one Department faced a financial shortfall, the agency director would not have authority to cut programs in another Department to fill the deficit.

While the dollars matter, stakeholders were also concerned that public health and mental health would be deprioritized and under-recognized in an agency model, similar to their perceived experience in a merged department. Several individuals pointed toward the merger of the California Department of Mental Health into the California Department of Health Care Services (DHCS) in 2011 as an appropriate parallel, calling mental health issues "functionally forgotten" at the State level and citing a dearth of communication with DHCS and senior Health and Human Services leaders.[30] Stakeholders expressed fear that an agency would similarly detract from attention paid to population health or mental health activities and goals. "The mental health client took a back seat for many years and now they are actually sometimes in the driver's seat. It would be a shame to lose that progress." Another commented, "Mental health gets steam-rolled by other the Departments already; won't that get worse?" "We'll be the ugly step-child," said one population health expert. A DMH consumer expressed concern over "loss of focus and funding for mental health, even to the point that our coalition groups

[30] This view of the State's merger of mental health and physical health was not unanimously shared. Several stakeholders commented that major progress on mental health and substance abuse issues would not have been made without the merger, such as the expansion of treatment for mild to moderate mental health disorders. A similar sentiment was shared regarding the movement of the Department of Alcohol and Drug Programs into DHCS in 2013; this shift was thought to be a primary factor in support for the expansion of the Drug Medi-Cal benefit and Drug Medi-Cal waiver design. Those who supported the State's reorganization viewed antagonism to the mergers as based on people's perception and experience of engagement in, for example, various State advisory groups, and not as reflective of actual attention to mental health and substance abuse issues at the policy level.

will be disbanded". "Mental health and population health will be swallowed up by health services." Others took a more personal view of the risk. "Change is scary when you are the most vulnerable, disadvantaged person in the room; you are scared you will be left behind." The suspected dominant agency was not always DHS. Several stakeholders expressed concern about how substance abuse would be impacted, particularly if it was moved within DMH, with many people stating they feared that SAPC would be subsumed by mental health or "overrun by mental health professionals not appropriately trained to treat addiction."

In contrast, others felt an agency structure would be best able to draw attention to a complex and comprehensive set of health-related activities. They felt that while not perfect, society and health leaders today had a far greater and more nuanced understanding of the critical role of population health and mental health activities than was the case in the 1970s, or even in the late 1990s and early 2000s. There is broad recognition of evidence that early investment can yield long-term savings: Substance abuse and mental health treatment has been shown to save up to seven dollars for every dollar spent due to averted medical and societal costs (e.g., avoided incarceration).[31] There is also ample evidence on the effectiveness of health promotion activities, including those that target clinical, social, and behavioral interventions.[32] This broad acceptance may reduce the likelihood that an agency would lead to a deprioritization of a broad and diverse set of health-related activities.

Practical steps that can help build confidence that the needs of each Department will not be deprioritized or defunded in an agency include the following:

- *Select an agency director with experience in all three areas:* Selecting an agency director who has leadership experience in all three fields: mental health, public health, and physical health, can help to establish credibility, build trust, and decrease the likelihood that the agency will narrowly advocate on a limited set of issues.
- *Increase transparency into Department budgets:* Each County Department's budget is shared publicly, but its style and length make it challenging for people to understand. The development of clear, concise Department-specific budget summaries, demonstrating the size of different funding streams and their uses, with historical comparisons, would be a valuable source of information to the public and could help to increase the practical level of transparency into County budget processes, reducing the likelihood that individuals or groups feel Department funding is being inappropriately diverted.
- *Clearly communicate any administrative savings from implementation of an agency structure:* Over time, Departments may choose to move certain administrative functions to an agency level when doing so would demonstrably improve service levels and help to reduce costs. The amount of total savings and uses of these funds should be clearly summarized and shared with the public.

Risk of additional layers of bureaucracy

One of the most commonly cited potential drawbacks of an agency is increased County bureaucracy, additional layers, and "big government". As anyone who works in or with the County knows, the effect of too many layers is delayed services and increased costs. While delays may harm individuals who use County services, they are especially detrimental to disadvantaged populations who are already challenged with accessing the system and thus exacerbate health disparities.

[31] Substance abuse: Ettner, SL, et al, (2006). "Benefit-cost in the California treatment outcome project: does substance abuse treatment 'pay for itself'?" Health Services Research, 41(1): 192-213. Mental health: Cutler, D, et al, (2003). "Your Money or Your Life: Strong Medicine for America's Health Care System." *Oxford University Press.* "Best Return on Investment (ROI): Mental Health and Substance Abuse Treatment." *National Alliance on Mental Illness. (2009).*

[32] Smedley, BD and Syme, SL, eds. (2000). "Promoting health: Intervention strategies from social and behavioral research." *Institute of Medicine.*

The concern about bureaucracy stemmed from two assumptions: 1) that an agency would indiscriminately place key administrative and operational units (e.g., finance) at the agency level, rather than leaving them within the Departments where they would be close to their programmatic and executive leadership and 2) that an agency's leadership would itself contain multiple layers with responsibilities for approving departmental actions, with corresponding overhead costs that would have to be funded by the Departments. Department personnel described a fear of "losing control" and having "diminished influence" if critical functions moved to an agency level, and of having "to work through yet one more layer of County bureaucracy for everything from ordering a pen to executing a contract for critical services."

The degree of bureaucracy is dependent on the agency's structure. Taking these concerns into account, the following structural characteristics would help to mitigate the risk that the agency would introduce more bureaucracy into the system.

- *Maintain a flat/horizontal organizational chart at the agency level.* Multiple reporting layers can contribute to administrative costs, redundancy, and bureaucracy, and reduce the degree to which management is actively involved in decisions and operations. To avoid these risks, the agency should minimize multiple reporting layers within the agency.
- *Pursue placement of administrative functions at the agency level only when there are clear net benefits of doing so.* There was broad agreement that functions should only move to an agency level if there was a clear and demonstrable benefit of doing so, taking into account both impact on services/programs and also administrative efficiencies and cost-savings. Stakeholders agreed that dual placement of functions at both the Department and agency (e.g., retain HR exams unit within the Department structure but also add an exams unit at the agency level) would increase bureaucracy, cost, and would hamper operational efforts. Similarly, movement of an entire organizational unit (e.g., finance, contracting, HR) could risk destabilization of critical program support functions and should be done only after careful study.

Many stakeholders also specifically voiced that the agency structure would diminish a Departments' voice with the Board of Supervisors. It was commonly assumed that the Department heads currently report directly to the Board, rather than to the County Chief Executive Officer and, until very recently, to the Deputy Chief Executive Officer for the Health Cluster who then reported to the County CEO.[33] Despite this lack of a direct reporting relationship to the Board, all three Departments have frequent and direct communications with individual Board offices and the Supervisors themselves. This open communication reflects both the importance of health-related issues in the County and also the ability of Department personnel to develop strong relationships with Board offices. Despite Department-Board communication that exists, some felt that the Deputy CEOs and CEO hampered those open lines of communication with the Board and that the communications would have been more robust had there been a direct reporting relationship to the Board, while maintaining and respecting Brown Act requirements.

Often individual units, facilities, or programs within each department also enjoy similar relationships with Board offices without communications being funneled through the department head. It would be neither feasible nor productive for a department head to interfere with those relationships; a similar fact holds true for an agency director. Access to the Board is not solely a reflection of one's position and reporting structure. Open and direct lines of communication are a reflection of relationships built over time, the Board's level of trust and confidence with the involved staff, and the importance of the issues at hand. As one way to support and encourage continuation of direct lines of communication between Department heads and the Board, the Board could request regular public hearings on progress in implementing the agency in which Department directors, and not just the agency director, are requested to speak before the Board.

[33] The Deputy CEO/cluster lead position was functionally eliminated from the County CEO structure in December 2014; the associated items were approved for permanent deletion in February 2015.

Having one of the three Department Heads serve as the agency Director would be consistent with an effort to reduce administrative layers and agency costs. This idea, however, was met with intense criticism by a number of stakeholders based on an assumption that it would lead the agency director to favor the department he/she ran, prioritize initiatives related to that department, and siphon resources in a way that would benefit that department. They thought that the appointment of one of the existing department heads as an agency director would lead the agency to focus disproportionately on the director's department, further risking the neglect of other critical County functions. Even if that individual was able to focus on the breadth of activity across the system, some feared this would come at the price of neglecting focus on his/her home department. "[Having a department head also serve as the agency director] would be an absolute show-stopper." "It's not three departments on equal footing. If there are disagreements, it's no question who would win. The agency director wouldn't be able to be a fair arbiter if they are also a department head." To increase fairness and transparency, the Board could consider conducting an open, competitive recruitment for the agency director position, considering various candidates rather than immediately appointing an existing Department director as the agency director.

Risk that agency will require financial investment for administrative positions

A number of stakeholders felt strongly that if an agency is created, the actual cost and budget of the agency and the way in which these funding needs would be met should be identified in advance, based on an expectation that the agency's administrative structure would need resources to be effective. The degree to which an agency would require funding for administrative positions would depend to a large extent on the structure of the agency. A large central agency with multiple new administrative positions and layers would both increase bureaucracy (see section above) and increase costs to the County. However, this is not the only way to structure an agency.

A more economical approach to an agency would involve creation of a lean structure that would support coordination and strategic direction. Rather, individuals would be identified who would perform dual roles that are complementary of current assignments to help lead integration activities in a specific field. The goal would be to have this model build off of the strengths of each Department and its personnel. These individuals should be selected because they have the appropriate mix of experience, expertise, broad knowledge of work in the three departments, professional strengths, and leadership style to be effective in this type of dual role.

While this approach has the advantage of minimizing cost and bureaucracy, several stakeholders criticized it as unrealistic, thus compromising the agency's ability to make progress in achieving service integration goals given people's inability to take on both roles. Further, this structure was thought to erode Departments' ability to meet their existing commitments or could result in an agency disproportionately staffed with people from one Department. They viewed an agency-level role as being a full-time job even if there were sizeable synergies with the person's Department-level role. One suggestion for making this model more feasible included having the assignments to dual-roles be time-limited. They also thought that this model would prove ineffective and that, over time, the agency would need to ask for additional funding from the County to finance agency operations, or would need to take this funding from the Departments' individual budgets to fund agency functions.

If a structure is implemented that does require new positions, the process for identifying funding should be transparent and subject to Board approval. However, at this time the CEO does not support an agency structure that would require additional financial investment by the County.

Risk that Departments will lose focus on the full breadth of their current mission

DHS, DMH, and DPH have distinct missions. They each employ a different mix of activities in pursuit of their mission, including those related to policy development/advocacy, regulatory functions, population health programs, and direct clinical services. A health agency would naturally focus on those areas where there is synergy in working more closely together and would not focus on those areas where there is no benefit from greater collaboration. Stakeholders raised concerns that in doing so, the time, energy, and resources of each Department may be shifted away from critical activities that are not the focus of the agency. An agency that focused only on the area of overlap between the three Departments, to the neglect of initiatives and priorities with other County Departments would be "an epic failure," as one stakeholder put it. These concerns exist on a number of levels and would need to be handled carefully under an agency structure.

- *Impact on constituent base of each Department:* Beyond specific programs, population health stakeholders called attention to the different scope of the three Departments with DPH's mission encompassing all ten million LA County residents rather than any single subset. DPH's responsibility in population health extends beyond the subset of individuals that are receiving care in DHS' delivery system. If too closely aligned with DHS, it could distract from DPH's broader vision, or create an impression that DPH will support DHS' obligation to achieve population health goals above and beyond its level of support to other healthcare delivery systems in the County. Stakeholders questioned whether DPH would be able to practically continue programs serving all LA County residents rather than those who use DMH and/or DHS for clinical care. They saw this as a major reason to question whether there were sufficient benefits to public health in joining the agency. "I understand the clinical problem we are trying to solve for DMH and DHS, and perhaps for the personal care side of DPH. Services at the point of care operate in isolation, are inefficient, impossible to navigate, and leave crater-sized cracks for people to fall into. I don't, however, see the problem we are solving in bringing population health along for the ride."
- *Impact on roles and programs not involved in integration efforts:* An agency risks de-prioritizing areas that are not natural areas for interdepartmental integration such as DPH's work on restaurant inspections, childhood lead poisoning programs, etc.
- *Impact on collaboration with other County Departments:* DHS, DMH, and DPH work collaboratively with other non-health County departments on a variety of issues. Stakeholders questioned whether this high degree of interaction and collaboration would take a backseat to integration efforts that focus solely on DHS, DMH, and DHS. As an example, mental health staff mentioned that the vast majority of DMH's work that crossed over with other County departments did not involve either DHS or DPH, specifically citing programs involving Probation Department, Sheriff's Department, DCFS, DPSS, and CSS. DHS and DPH both are similarly involved in a number of collaborative activities with other County departments.
- *Impact on contracted providers and agencies:* Stakeholders questioned whether a health agency would focus disproportionately on directly-operated clinics at the expense of community agency partners. The Departments provide a different mix of services through contracted provider arrangements. While the agency would be comprehensively responsible for all services provided, regardless of whether they are directly operated or contracted out, many individuals and private provider groups felt there may be tendency to favor the needs of directly-operated sites.

The risk of narrowed focus depends in large part on who is selected to be the agency director. An agency has a greater risk of narrowing the focus of each Department if the individual selected to lead the agency does not have robust experience, knowledge, and appreciation of the issues central to each Department. An individual with experience in only one area may be most likely to focus efforts within an agency on those areas where he/she is most comfortable. The success of other local governments who utilize an agency structure but still have strong component departments was often attributed to the credentials of the agency director. For example, New York City's Public Health Department, which reports to an agency director, was thought to be as strong as it is in part because of the national prominence of its prior agency directors in the

field of public health. Several stakeholders commented that an open, competitive process for selecting the agency director would help to ensure the County appoints the person best suited for the position. An agency should not be developed for one person's talents and charisma.

The fundamental characteristic of an agency structure, in which the three Departments maintain department status, helps to mitigate the above concerns, as opposed to a structure in which two departments move under a third and lose their department status. As departments, DHS, DMH, and DPH would be expected to fulfill the entirety of their mission, establish strategic priorities and goals to accomplish that mission, and to set budgets accordingly. The agency would help to ensure that goals affecting the entire County are prioritized alongside these activities, but not in place of them.

While most stakeholders expressed concern that the agency could limit the scope of each Department, some held the opposite opinion. They felt that, rather than hampering efforts to achieve Department-specific goals, an agency could help Departments focus additional time and energy on the areas that are uniquely theirs. Adding new energy and perspectives to tough, long-standing County problems related to health integration could free up time within Departments to focus on their unique scope of services.

Risk that cultural differences will compromise integration efforts

Naturally, the three separate Departments have three distinct cultures, though often there is diversity of cultures within each Department as well. The culture of each Department is apparent in everything from its organizational structure, how administrative tasks such as HR and contracting are performed, approaches to collaboration and decision-making, the degree of centralization vs. regionalization, and methods for ensuring the cultural fit of their service and programmatic mix. These characteristics are an important part of what has led to the successes of each Department. Often, stakeholder sessions revealed that those working both inside and outside the County have much to learn about the cultural characteristics and strengths of each Department. Stakeholders closely identified with one Department often spoke of the other two in derogatory terms, relaying a single experience or an assumption based on the historical reputation that is not representative of the whole picture, of current practices, or of forces outside the influence of the County. Fear of the unknown and of how the agency would engage with clients/consumers/patients and external community partners also emerged as a strong driver of concerns over cultural friction. "I'm afraid the agency won't give us a voice in the way that this Department does. The leadership here listens to and values our concerns." "I worry the other Departments don't work collaboratively with communities of color." "The voice of the family and consumer is not strong even here; I fear it will get worse in an agency."

The cultural differences between DPH, DMH and DHS should not be underestimated, but should also not be considered an insurmountable barrier. One of the greatest challenges but also richest opportunities of the agency model will be to lead in such a way as to maintain the positive attributes of each Department's culture while building understanding of others' strengths and supporting the development of new sub-cultures so that staff can be fully engaged in integration activities. As one stakeholder mentioned, "by really looking at the differences between the Departments, the County may fuel the creation of a wider range of services and programs." Cultural differences can be identified and leveraged to increase the capacity for integrated action.

Some stakeholders pointed to challenges in the creation of the Department of Homeland Security in 2002 as a potentially relevant case study. Its creation represented the largest restructuring of the federal government, bringing together under one Department twenty-two different agencies that were formerly subordinate to eight different federal departments. Since that time, the Department of Homeland Security has faced a large number of departures from high-level staff blamed on clashing departmental cultures, an increase in lucrative private sector security jobs, and a high degree of pressure from

elected officials and the media. To address the culture-related portion of these challenges, the Homeland Security Advisory Council's Homeland Security Culture Task Force generated a set of specific recommendations.[34] They noted the importance of clearly defining the new Department's role in establishing the vision, policies, strategies, and performance objectives needed to protect the United States, facilitating coordination between units, and empowering divisions to execute their respective goals rather than having primarily an operational role that duplicated the focus of the component organizations. The report suggested several steps to reduce cultural friction, including the need to build trust between component parts over time, to strive for a "blended" rather than single organizational culture that retains the strength of each and identifies with the shared mission, ethic, and vision of the agency, the importance of empowering front-line staff, and the need to be a good partner to external organizations through communication and collaboration. These recommendations are equally applicable to an LA County health agency.

Finally, it is important to note that cultural friction may arise even without an agency as the Departments continue to seek ways to better integrate services. To the extent the agency accelerates this rate of integration, it may raise cultural differences that are best addressed in the open, rather than left to languish, compromising integration efforts over the long-term.

Risk of medicalization of community-based mental health

The community mental health system as led by DMH relies on a recovery-based model of care that emphasizes personal empowerment and resilience, social support, community connectedness, wellness, and the pursuit of hope and meaning in one's life as a means of reaching one's potential in life. This is in comparison to a medical approach to mental illness that defined the field in previous decades, relying on diagnosis of disease, identification and treatment of symptoms and signs, and heavy use of medication and continued diagnostic testing. The recovery model is much favored by mental health providers, clients, and advocates, many of whom fear that closer integration with DHS in particular will result in a shift away from recovery toward medicalization of mental health treatment. For the many individuals who have experienced first-hand the benefits of a recovery approach, and for the providers and advocates who serve them, this is a frightening possibility.

While the term "recovery" is not widely used in the physical health realm, the concepts underlying the model are not foreign to many physical health providers. Many clinicians acknowledge the failure of the medical model to address the root issues affecting their patient's health and life, particularly in low-income and other vulnerable populations, and believe in an approach that emphasizes individual empowerment and that addresses the social determinants of disease. Issues of poverty, homelessness, unemployment, community violence, lack of access to healthy food and parks, social and spiritual isolation, and lack of purpose are large drivers of symptoms that land individuals in emergency departments and outpatient clinics and must be addressed. Despite this recognition in the physical health community, particularly among safety net providers, many providers in the physical health care system still manage patients first in the medical framework, and then address social, psychosocial, and environmental factors when medical intervention doesn't yield the expected result. They order diagnostic tests to rule out unlikely but potentially dangerous diagnoses when more obvious social or environmental causes are left unaddressed. They prescribe medications to treat the first sign of disease, without attention to the patient's other needs or willingness to engage in their own recovery. They manage individuals with chronic diseases with narrow attention to medications and laboratory values rather than emphasizing coping mechanisms and social supports.

[34] Homeland Security Advisory Council, (2007). "Report on the Homeland Security Culture Task Force." Accessed March 23, 2015 at: http://www.dhs.gov/xlibrary/assets/hsac_ctfreport_200701.pdf

There is much that the physical health community can learn from the mental health community about empowerment, hope, wellness, and recovery. In the best of worlds, this exchange of information would be facilitated through education about recovery, integration of recovery models into primary care and even emergency or specialty care settings. But while this learning is happening, it will be important to ensure that the physical health world's reliance on medicalization doesn't seep inappropriately into the community mental health model of care. To help prevent this from happening, medical leadership should remain separate between DHS and DMH and the agency should maintain strong roles for external coalitions and groups that emphasize recovery models.

Risk of disrupting existing service models and the staffing structures and partnerships they rely on

Many stakeholders were concerned that agency leadership would establish new different expectations for engagement with external partners and contractors with adverse effects on the individuals who benefit from these services and the providers/partners who appreciate the structure and tenor of current County relationships. Stakeholders voiced anxiety about how and where individuals would access care, fearing that individuals would be forced to change where they receive services, disrupting delicate and long-standing therapeutic relationships. They feared that any changes made would not be clearly communicated to the public. In particular, contracted providers doubted that a new agency director would be as supportive of existing external relationships and contract terms as the current Department leadership. Questions posed by external stakeholders focused both on whether or not services would be cut but also whether or not contracts would be changed even if service levels were held constant. In one exchange with a contracted provider: Provider: "Are there going to be reductions to service contracts?" CEO staff: "No, service levels will be maintained." Provider: "I don't mean if services in general will be maintained. I mean are you going to cut *my* contract for providing those services." On a few occasions, stakeholders compared the agency to the roll-out of the State's Coordinated Care Initiative, anxious over whether or not the agency would continue to keep them "in network" with implications for both provider reimbursement and also continuity of care.

This issue is not reserved for contracted direct service providers. Similar sentiments were shared by private organizations that provide non-patient/client care services (e.g., family support, administrative support, and ancillary services). "Some bureaucrat I've never met is going to say 'we don't need [organization] anymore." In some cases, the feedback is connected to specific individuals. "My organization has a great relationship with [Department leader]; I don't want things to change once the buck doesn't stop there."

These sentiments are not a drawback of the agency itself. Rather, they reflect general anxiety that comes with new leadership and a lack of familiarity with the goals and priorities of the agency and its director. Once established, the agency can reduce this level of anxiety by establishing relationships with external partners, clearly communicating the agency's priorities and commitment to not disrupt existing services that are serving individuals well. When changes are considered, they should be done in an open and transparent manner, fully engaging external partners throughout the process.

While many stakeholders expressed concerns about how their role might be reduced, others saw the agency as an opportunity to expand their reach, helping to forge new connections with populations that could use their services or with Departments who should be aware of their capabilities and programs. While some external organizations have well-established relationships with two or three Departments, many have very strong ties to only one, despite offering services that could benefit a broader set of individuals. Examples include community clinics able, or potentially able, to offer primary care, mental health, and substance abuse services; family support organizations; consumer advocacy groups; and independent City Departments of Public Health who are often disconnected from services provided within the County. Time spent building relationships, developing partnerships, and forging strategic alliances could help to bridge these gaps, benefiting the individuals served and the external entity through increased reach.

Risk agency planning will distract from the work of integration

Many individuals describe an atmosphere of distrust and suspicion of the process for evaluating the agency model and its goals, particularly given the absence of a stakeholder process before the item was brought for discussion by the Board. Some questioned whether or not an agency could recover, begin to build trust with these stakeholders, and focus time and attention on the work to be done. This is in part a fear of change: "Our director is an incredible ally; we don't trust that the person that comes next will be the same." "We fear we will be led by someone who doesn't understand us and won't listen to us." But it also goes deeper than that. A distrust of the process itself exacerbates this fear and, if not ameliorated, could complicate the real work of the agency in integrating care. It will be important for the agency director and other Department leadership to have the necessary skills, experience, and temperament to build trust-based relationships with stakeholders over time.

Additionally, some stakeholders raised the practical concern that focus on planning an agency would distract from the real work of integration that should be the primary focus for the Departments. One stakeholder commented: "Let the Board's answer be a simple yes or no; a lukewarm 'let's study it for a while' would be a terrible waste of everyone's time." Others, generally those most critical of the agency model, felt a long planning period was necessary before the County "jumped into something it didn't want." "We've been married before and it didn't work; we should spend more than 60 days deciding if we want to get married again." If an agency is created, there is also concern about how the process of establishing the agency will affect services. They described being fearful that the energy that would be spent investigating the feasibility and return on investment from various administrative restructures (e.g., HR, finance), rather than focusing on service-oriented initiatives. "The process of building an agency is a distraction from the real work; it could be a transitional quagmire lasting years."

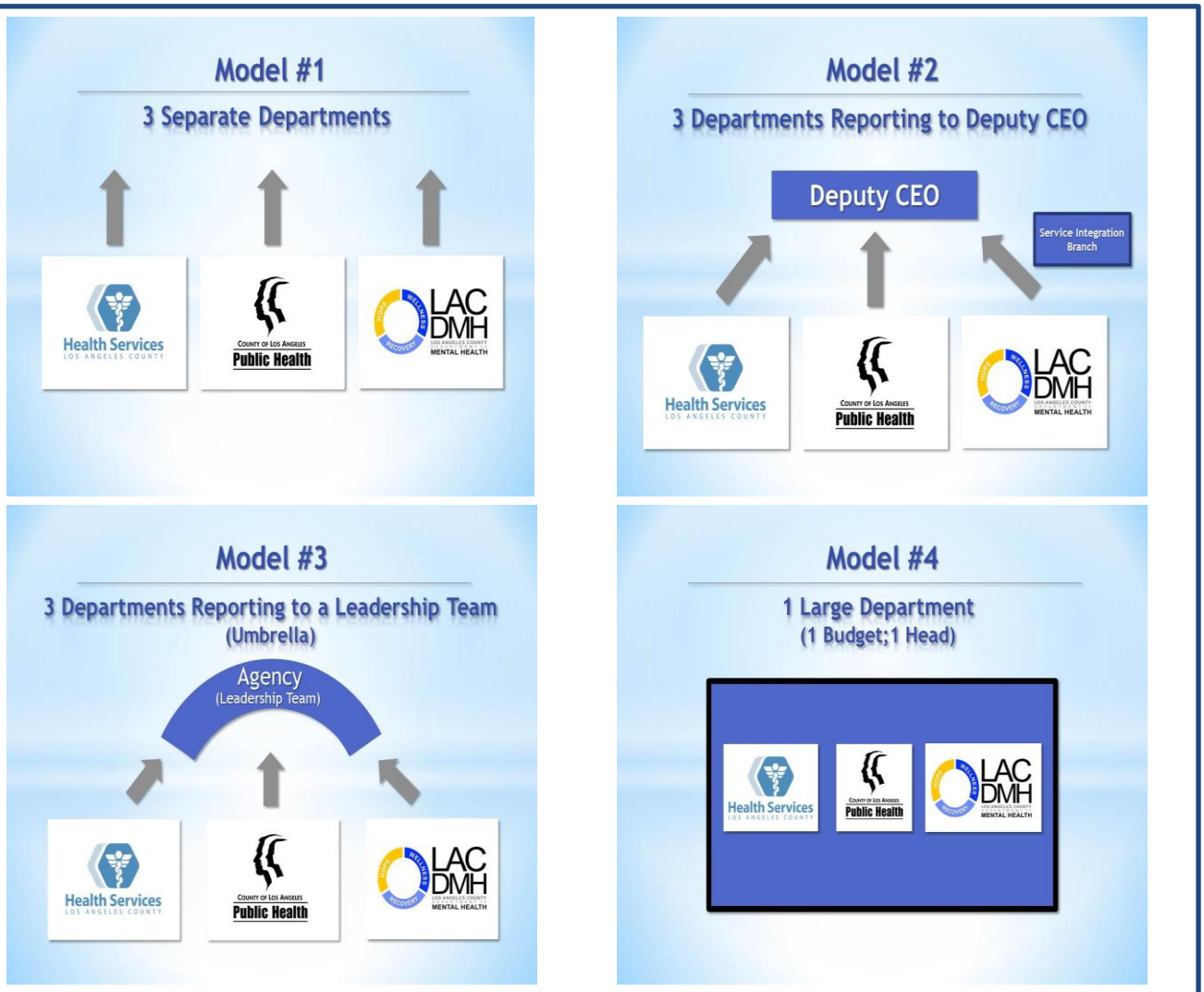
Certainly the real work of an agency is in integrating services by establishing and achieving shared goals. The goal is not the creation of a complex organizational structure. This is an additional reason, beyond the concerns of bureaucracy noted above, why the agency should be structured in a lean and simple manner. If the Board votes to create an agency, the necessary ordinance changes can be accomplished within a couple of months.

Proposed Structure

Neither the creation of an agency nor its structure will itself lead to service integration. The agency's structure can, however, be an important enabler of integration. The purpose and mission of the agency is to provide an integrated, cohesive, and operationally efficient means of leading changes needed to improve the health and wellness of LA County residents. It would have the authority and leadership needed to establish a clear vision, policies, strategic priorities, and performance objectives for health-related services in the County while empowering component Departments to focus on their unique roles and responsibilities. The agency would ensure resources are available to effectively and efficiently execute each Department's individual and collective missions. The agency would be accountable for achieving the health-related goals of the County, for supporting integrated operations, and for ensuring coordination and alignment of individuals or groups within each Department with divergent perspectives and strategies. It would work as a catalyst for the work of integration. The agency would help to capture system-wide efficiencies and simplify and streamline operations. While not primarily an operational entity, the agency would be a critical body for helping to overcome organizational and operational barriers that would otherwise impede progress toward shared aims. It would do this through both its role in setting direction and strategy but also by playing a prominent role in communication, education, training, advocacy, and stakeholder engagement. Finally, it would play a strong role in political and legislative advocacy, exerting greater influence on areas of concern for the County than the three Departments could alone.

Many have argued "you don't need an agency to do this. The Departments can simply establish priorities and work together to achieve them." While technically possible, this view has not been proven feasible in practice as evidenced by failure to bring successful integration activities to scale across the County. The view also dramatically underestimates the amount of work and costs required at the operational level to make progress on initiatives and the pivotal role of leadership in setting vision, priorities, and removing barriers.

In recognition of this challenge, the Board's motion specified creation of a single unified health agency that encompasses all aspects of the activities performed by the Departments. This is one of four general models the County could use to organize its health-related Departments (see Box below). Notably, creation of an agency is not a merger in which three Departments would be collapsed into a single department. Agencies are common in government at all levels and are characterized by direct reporting relationships between the agency and its component departments, with those component departments maintaining their own unique structure, mission, priorities, and budgets. In contrast, a merger is a combination of two entities into one single entity. The combination of DHS, DMH, and DPH in 1972 was a merger, with three departments becoming one single department. The County has not previously employed an agency model in the organizations of its health departments. The difference is more than semantics and has multiple implications. First and as discussed above under the Risks section, departments have separately and individually appropriated budgets, with the Board of Supervisors having the sole power to increase or decrease Department budgets. This serves as an important safeguard for ensuring that funds for mental health, population health, and physical health remain dedicated to these purposes. Second, while cultural friction will naturally arise when inter-departmental teams begin working together in new ways (as it would even without an agency model), the Departments and department leadership will still be in place and are thus more able to maintain their unique identity and culture.



Four models for structurally organizing LA County's health departments:

- Model 1: Departments report completely separately to County leadership (e.g., Riverside County)
- Model 2: Departments report to a Deputy CEO or more recently to the CEO whose primary expertise is not related to health. Service Integration Branch, which sits outside Departmental structures, has some responsibility for departmental integration. (Current LA County structure)
- Model 3 (proposed agency model): The Departments report to an agency with expertise in health and responsibility for achieving health-related goals, including service integration (e.g., Ventura County)
- Model 4: Merged department. The Departments are combined to form a single merged structure. (e.g., Contra Costa County)

During the stakeholder discussions, several people questioned how the agency fits in the County's evolving governance structure more broadly. They asked how the former deputy CEO model that the County has now moved away from was different than the agency model. While similar on a County organizational chart, two key differences exist. First, the agency director would be someone selected specifically for their clinical expertise and reputation for effective leadership in the health arena. In contrast, deputy CEO's strengths were in administrative skills, system planning, and perhaps public sector financing, but were not health-specific. Second, the deputy CEO model did not include agency functions, whether

strategic, administrative, or operational. In contrast, an agency would have additional roles or divisions, even if very lean-staffed, that provided additional value for the Departments and for the County in terms of achieving economies of scale, capturing administrative efficiencies, and ensuring alignment between department units.

Stakeholders also asked how the agency model related to the Board's anticipated shift to a model in which it will take on a more active role in policy. Under this type of governance, the Board would need to rely on leaders actively involved in establishing and achieving specific priorities that are consistent with that policy. Reliance on an agency model can be seen as one way in which to support alignment and coordination of related departments' activities and facilitate progress toward service integration goals.

Placement of specific responsibilities and functions within a health agency

Before discussing specific responsibilities that could be placed within an agency, it is helpful to note the approach taken with stakeholder recommendations to revise the structure of units *within and between* Departments. Stakeholders volunteered several suggestions about shifts or "trades" in the placement of specific programmatic divisions that they thought could be made simultaneously with the creation of an agency. Some of the more commonly raised examples include: a) moving Emergency Medical Services from DHS to DPH, b) moving personal health services such as TB control, immunization clinics, and STD services from DPH to DHS, c) moving prevention and early intervention activities from DMH to DPH, and most commonly d) moving substance abuse control (with or without the prevention component of SAPC) to DMH or, less commonly to DHS. Thoughts on SAPC's ideal position were the most controversial, with several individuals also strongly advocating that SAPC remain within DPH or become its own separate department under an agency on equal footing with DHS, DMH, and DPH. Shifts of this nature are more operationally and organizationally complicated than the creation of an agency itself, given the impact on administrative support functions (e.g., HR, finance, IT) and the resulting separation from other clinical initiatives within the home department. Without commenting on the wisdom of each proposed move, no recommendations are made here to move units or divisions from one department to another. If an agency is created, agency and departmental leadership should carefully assess the benefits and risks of these or other possible shifts and make appropriate adjustments over time. The remainder of this section will focus on the structure of the agency itself, and not on the alignment of roles and programmatic units within each Department.

One defining role of an agency is that it hosts certain administrative functions as a means of helping to streamline operations and reduce duplication. Re-location and integration of administrative functions isn't itself a goal of an agency but such shifts can be an important catalyst for service integration, if done correctly. In considering whether and when an agency might place specific administrative functions at an agency level, several points emerged: the need to progress slowly, avoid duplication, stay lean, and respect departmental needs, nuances, and cultures.

Progress slowly: One benefit of an agency is its ability to streamline administrative functions, reduce duplication, and dedicate more funds to services of direct benefit to individuals and populations. While the possibility for efficiencies and cost-savings exist, these are long-term opportunities that must be carefully considered and planned for in order to avoid disrupting ongoing operations and services that rely on these support functions. Rather than rushing into a series of potentially disruptive changes, functions should only be moved when there is a clear strategic or operational advantage or economy of scale/efficiency to be gained, or when circumstances arise that present opportunities for change (e.g., personnel changes). Even when the possibility of savings exists, functions should only be moved to an agency level when there is demonstrable evidence that doing so will create a value-add in terms of improving service levels, enhancing departmental operations, and achieving economies of scale. Organizations are fluid; they need to be allowed to evolve over time based on the opportunities and challenges of the moment. As one stakeholder commented, "the natural

inclination would be to move things right away in order to save money but this would be very disruptive. These shifts, if done right, would take years."

Avoid duplication: To avoid unnecessary redundancy, layers of bureaucracy, and the risk that an agency would increase rather than decrease administrative costs, an agency should be careful not to duplicate units or functions. Rather, any shifts should involve a shift of administrative functions (or portions of those functions) to the agency level. Using HR as an example, it would not be wise to have each Department retain a full HR unit and also create an HR unit at the agency level. This would raise costs and increase the number of steps required to accomplish tasks within the county ultimately leading to delays in downstream services and programs.

Stay lean: In order to keep costs and bureaucracy low, it is best to structure the agency as a lean body. If, over time, certain functions move to the agency level, this would increase the number of staff reporting to the agency (vs. Department). However, as noted above, these moves would only be done when there was a clear value-add in terms of Departmental operations and if doing so would yield net savings. A lean agency would imply very few positions at the agency level and could involve the use of dual-roles, as described in the "Risks" section above, in which individuals within each Department are appointed to take on an additional strategic role at the agency level while keeping their existing Department responsibilities. These strategic leads could also have a matrix reporting line between them and the respective Departmental leads. This model maintains a lean organization and might be achieved at little to no added cost to the Departments or the County, relying instead on the identification of individuals within the Departments being willing and able to take on an agency assignment. With this staffing model, the lead employee must understand the functions and operational frameworks of each department to ensure that the agency-level strategy will take into account the unique needs and requirements of each Department while advancing a cohesive vision to support agency objectives. Dual staffing will require an investment of the time and energy of the lead individual, as well as departmental staff as they would essentially on-board the lead staff to all current projects, activities, barriers, opportunities, etc.

In some cases, rather than appointing a specific individual to coordinate work on a topic at the agency level, a particular unit could be designated as the lead for the agency for those areas while remaining within their department. In this center of excellence model, divisions with particular expertise on a given topic could support other Departments without having to relocate to the agency. As examples, DPH may be well-suited to provide a leadership role for the agency in grants solicitation, accounting, and fiscal management or employee wellness; DMH in providing instruction on use of the recovery model in clinical practice; and DHS in revenue maximization.

Respect Departmental expertise and culture: Small differences can have big impact on operations and on an organization's culture and strength. Moving functions to an agency level without attention to these nuances could compromise critical technical functions by reducing content knowledge of the division. The risks of moving the finance unit from the Division of HIV and STD Programs to an agency finance unit is one example raised given the specialized knowledge and expertise required to perform Ryan White-related finance services. These moves could also weaken the overall fabric of an organization if such a unit were a core part of the Department's identity. Some stakeholders raised concern that if DMH's family/advocacy unit were moved to an agency level, in an effort to spread best practices to both DHS and DPH, that DMH would lose connection with a unit critical to its core identity.

With these guidelines in mind, below are recommendations on the placement of specific functions at the agency vs. departmental level. As noted above, these positions could each be achieved by appointing individuals with dual roles within their home department and the agency. These moves should be considered carefully given concerns with this model described in the "Risk" section above.

As suggested by the human resources workgroup chaired by the Department of Human Resources, a Chief Strategic Officer position could be created at the agency level to oversee these individuals and help to achieve the strategic/operational

objectives of the agency. This would, however, come at a financial cost. For this reason, a decision about a Chief Strategic Officer position, or other deputy-level positions within an agency, should be made by the agency director once he/she is appointed by the Board.

Recommend prompt reassignment of whole units (or portions of those units) to an agency level:

1. *Data/planning group:* The agency model may facilitate the sharing of certain data and information for care and treatment purposes as well as for statistical analysis and planning. As to care and treatment purposes, it should be noted that each Department currently maintains separate privacy practices as well as authorizations for the release of information and consent forms. Even within Departments, these may be replicated or refined at a division or facility level. Thus, the County system of care currently is a complex and sometimes overlapping process and often does not engender an environment conducive to coordinated care.

   To address these needs, the agency should create a data/planning unit that would have responsibility for performing analyses needed for planning and program design activities. Examples of specific roles would include: performing data matches in a manner that preserves information privacy and security, leading agency-wide data governance activities, developing business intelligence function including development of performance metrics and indicators, performing geographic analyses, leveraging available data and analytic resources, and assisting in the data-based design of programmatic initiatives, such as high-utilizer program and coordinated case management functions.

   In development of this report, County Counsel was asked to explore the feasibility and legal issues related to this concept. Regarding improvement of information management for care and treatment purposes, Counsel concluded that the agency model would facilitate the Departments in adopting joint privacy practices and a universal authorization for the release of information. Counsel surveyed the agency models used in other jurisdictions and learned that they have a wide array of authorizations and consents to enable the sharing of client- or patient-specific information. Likewise, they have privacy practices that are implemented at the agency level so that they encompass all departments that comprise the agency. Counsel does not foresee significant legal obstacles to establishing similar policies and procedures in LA County. The agency must be cognizant that federal and State laws still provide heightened protections for certain information, such as that pertaining to substance abuse, mental health and STD and, as a result, the agency will require authorization from the individual to share this sensitive information. However, several other counties that have moved to an agency model have followed this protocol, facilitating improved care coordination for individuals served by multiple departments. As to information sharing at the agency level for statistical or planning purposes, an agency unit would be akin to the function currently implemented by the Service Integration Branch (SIB) of the CEO to support multiple County departments. Essentially, the agency would be interchangeable legally with the CEO's SIB in this arrangement. While DHS, DPH and DMH would still participate in SIB activities as needed for relationships with non-health departments, they would separately engage in data sharing projects at the agency level.

2. *Capital projects and space planning group:* As described in greater detail above, one advantage of an agency is the ability to better coordinate and plan use of County-owned and leased properties. Each Department has a unique inventory of facilities but also has several unmet needs including deferred maintenance issues, aging infrastructure, greater geographic access for clinical services, suboptimal floorplans and locations for current operations/services, etc. By having the agency take on a role in overall space planning, including management of capital projects, the County would be better positioned to create economies of scale, reduce cost, and improve the degree to which County-owned and leased buildings meet the needs of each Department as long as these activities

replace rather than duplicate similar activities undertaken currently by CEO. This function would not include actual facility management. These activities should remain in the Departments, closely aligned with clinical programs.

3. *Government affairs:* To ensure alignment in the County's policy on certain issues and create a stronger advocacy arm for health-related issues, the agency could have a unit dedicated to government and legislative affairs. This unit would not replace the policy units within each Department nor would it replace the role of Intergovernmental Relations in the CEO. Rather, it would be responsible for developing and/or consolidating, supporting, and advocating for positions that would be of benefit to any or all of the involved Departments. Positions recommended to the government entities would continue to be developed based on analyses and input from subject matter experts within each Department.

Several stakeholders also suggested that there would be substantial value to the County if two additional functions existed at the agency level; these are listed below. Further discussions should be had among Departmental leadership to assess whether there is support for creation of these or similarly-focused units.

1. *Workforce training.* The goal of this unit would be to foster staff engagement and development and to promote a culture of continuous improvement well versed in models of care the support service integration. The unit would help design and implement education and training on, for example, new care models and practices, techniques to identify and solve problems, and consumer engagement and cultural competency.
2. *Consumer affairs/care navigation/ombudsman*: Navigating the services provided in each of the three Departments can be challenging. A central unit could help individuals and external entities access services, find clear answers to questions that are not department-specific, and facilitate open dialog with individuals and community stakeholders.

A number of stakeholders questioned whether it would make sense to immediately move IT to the agency level as a shared function. While such a move might result in better aligned strategy, coordinated activities, and economies of scale with respect to IT support, etc., there are also risks. First is the concern that the agency would divert resources away from critical Public Health IT needs including those of Environmental Health, Disease Surveillance and Control and Emergency Preparedness and Response. Second is the concern that IT staff would be devoted to the implementation of the agency structure rather than the achievement of the desired clinical or operational objectives. Clinical service integration objectives may best be met by having IT entirely at the agency level over the longer-term, but progress can still be made by appointing an individual to be responsible for ensuring the strategic alignment of IT initiatives in each Department. For this reason, IT is included below as a strategy role and not here as the complete movement to the agency.

Over time, the Departments and agency should continue to examine whether a particular function would be best positioned at an agency, rather than a Department level.

<u>Recommend strategic/functional roles within the agency, possibly by appointing individuals to serve a dual-role at both the agency and Department level</u>

The purpose of agency strategy roles is to foster coordination, alignment of policy and strategy, and, where appropriate, to serve as a dotted-line supervisor for each Department's lead on a specific content area in a matrix reporting structure. This position is not primarily an operational role, but will have a strong role in helping to remove obstacles that may impede success on particular initiatives.

1. *IT strategy:* While each Department should maintain responsibility for their own IT operations and should continue roll-out of their applications, it will be critical for the agency to align IT strategy and prioritize certain IT initiatives if it is to make progress integrating services. An individual at the agency level focused on IT strategy

would ensure decisions made are complementary or at least not antagonistic, would identify opportunities to leverage economies of scale, and would help to support priority service integration goals, while making sure Department-specific projects are not compromised.

2. *Revenue maximization:* All three Departments could benefit from having an individual whose role is to understand the revenue streams within each Department, able to recognize opportunities to draw down additional state or federal funds. Part of this individual's responsibility would also be to clearly communicate the sources and uses of different revenue streams as a means of increasing confidence that the agency is preserving the intended use of different funds.
3. *Service contracting and procurement strategy:* Movement of contracting and purchasing functions to the agency level would risk severing a critical link between contract development and program business owners. However, there are opportunities to better align contracting/purchasing strategy, such as through improved coordination on use of master agreements, RFP development, contract monitoring tools and protocols, etc.
4. *Human Resource (HR) /Employee Relations (ER):* Without detracting from the role of the CEO and DHR with respect to HR and ER functions, there would be advantages to an individual focused on HR/ER issues, especially if they are focused on highly specialized content areas unique to health-related fields or the needs of certain health programs shared by the three Departments but not generally shared by those outside of DHS, DMH, and DPH.

Other central strategy roles that could be considered by the agency director over time are:

5. *Managed care strategy:* As each Department further develops its health plan and managed care relationships, it will be increasingly important for the agency to have a holistic view of the scope of activity and contracts being developed. A managed care lead could also identify and help implement joint contracting approaches as opportunities arise.
6. *Emergency response:* An individual at the agency level could help to coordinate emergency/disaster related activities in each Department so that the collective Department efforts are more nimble and coordinated in case of emergencies or public health threats.

The role of the Health Officer

The Health Officer plays a critical role in a County health system and has specific statutory roles and responsibilities. In these roles, it is critical that the County ensure the Health Officer is able to act autonomously from other agency personnel and also is strategically positioned to be able to work collaboratively with each Department. The Health Officer will continue to be an unclassified position within DPH. To preserve the autonomy and public accountability of the role, the Health Officer should also have a dotted reporting line directly to the Board of Supervisors.

Alternative agency models

Internal and external stakeholders often stated preferences for alternative models in which the County could structure the three Departments in order to support goals of integration. Provided below is a brief description of additional ideas raised, and notable advantages and disadvantages of each.

1. *Fundamental realignment of Departmental functions:* A few stakeholders suggested fundamentally restructuring the Departments into three new entities: one focusing on institutional care (hospitals, locked psychiatric beds, etc.), one focusing on community- and office-based clinical services (both behavioral and physical health) and one

focusing on population health. While appealing in its separation of services by category, skillsets required, and resource intensity, implementing this model would likely exacerbate already prominent challenges with care transitions. On a more practical level, it would require fundamentally restructuring virtually all aspects of the Departments, teasing apart administrative and program support functions, finance, clinical functions, etc. This would be a resource-intensive, multi-year undertaking and even then it is not be clear whether there would be net value to the system and LA County residents.

2. *Agency focused only on clinical service delivery:* Many stakeholders agreed with an agency that would unite mental health, health services, substance abuse treatment, and DPH personal care services, but suggested more limited value from combining the population health and health protection functions of DPH. The main advantage of keeping population health functions separate from an agency would be as a means of ensuring current resources continue to be dedicated to an area that is historically underfunded. Some also felt that maintaining a separate population health department would result in an increased ability to recruit population health experts to leadership roles, including notably the currently vacant DPH director position. Critics of this model generally felt there was a significant value to integrating population health functions more closely with the delivery system. Reasons, as described in the Opportunities section above, include the ability to leverage the experience, data, anecdotes, and trends in the world of direct clinical care and use these insights to inform the design and prioritization of population health initiatives and policy-making activities. Finally, implementing a "delivery system only" agency would require dismantling DPH, splitting it into two pieces, one that goes to the agency and one that remains a separate department. This would be a time-consuming and resource-intensive task without clear benefit for the residents of LA County.
3. *Health and Social Services Agency:* Some stakeholders felt the creation of a health agency missed a bigger opportunity to better coordinate and align all health and human/social service functions within the county. They questioned why the County was not considering inclusion of the Department of Public and Social Services, the Department of Children and Family Services, Community and Social Services, and homelessness programs located within the CEO. These individuals generally accepted that such an expansion of the agency's scope was not under consideration.
4. *Health czar and/or health council:* Several stakeholders raised an alternative to the agency model described as a "health czar" and/or "health council" model. In this model, an individual would be appointed to help guide the Departments but would not be directly responsible for Departmental functions and would not have any direct reporting relationship with the department heads. The czar's role would be one of coordination, alignment, and consensus-building, but would have no direct authority. Advocates of this model argued the czar could help set strategic priorities for integrated care and could help resolve disputes between the Departments. In many descriptions of this model, the czar was envisioned as working with a broader team or council of individuals as a leadership/advisory body. This council would be comprised of each of the three Department heads as well as other individuals, such as possibly Commission chairs, clients/consumers/patients, providers, labor, etc. This council may be granted decision-making power, but as with the czar would have no direct authority to implement changes within the Departments. Critics of this model argued that it offered "accountability but no authority" to get things done on a practical, operational level.
5. *Health authority:* Finally, several stakeholders suggested that, rather than or in addition to a health agency, the County should consider establishing a health authority. A health authority is a public entity that has an autonomous or semi-autonomous governance structure, operating to some extent independently from local government and associated regulations, being governed instead by a separate board, though often comprised or with involvement of local government. While the particular benefits depend on the exact structure, a health authority often has greater flexibility in such administrative tasks as contracting, procurement, hiring, etc. A health authority model has been periodically considered by the County, most recently in 2004-05 but was ultimately rejected and has not been seriously considered since. There are multiple models of health authorities. Some

contain only hospitals and/or clinics (e.g., Alameda Alliance for Health, New York Health and Hospitals Corporation) whereas some incorporate a broader set of health-related functions, including hospital/clinic functions but also county roles in public health, mental health, and substance abuse (e.g., Jackson Health Trust in Miami-Dade County; Denver Health). As with the social services agency proposal, individuals advocating for a health authority model generally accepted that it was not under consideration.

Implementation Steps and Timeframe for Achievement of an Agency

Legal and technical steps required to create an agency

Currently, the three Departments are each created under separate ordinances contained in Title 2 of the Los Angeles County Code. Nothing in those ordinances is inconsistent with creation of an agency. The County's Charter requires the Board to provide by ordinance for the creation of offices not required by law. Therefore, at the Board's discretion, it could adopt an ordinance formally approving the creation of the agency. Such action is within the Board's authority under the police powers granted by the California Constitution. The agency ordinance would bring those separate Department ordinances under the umbrella of the agency structure by reference, with reporting lines from the Department heads to the agency director built into the agency ordinance. The position of the agency director also would be created in the agency ordinance itself. The authority of the Board to appoint the agency director, as it does for the directors of DHS, DPH and DMH, would also be part of the agency ordinance as provided in the County's Charter. The agency director position may be filled by any individual inside or outside the County as the Board chooses.

If necessary, the ordinance will also amend discrete provisions contained in each Department's ordinance if roles under the agency structure need to be clarified or any existing provisions are inconsistent with the agency structure. To the extent salaries or job titles must be modified to implement the agency, certain provisions of Title 6 will also require amendments. This could be accomplished using the ordinance that creates the agency and its Director. These amendments can be made over time as the agency structure and roles evolve.

As with the majority of ordinances, the agency ordinance must have two readings at a Board meeting. The agency ordinance would be placed on the agenda for introduction, then return for adoption at a later meeting, which is typically the following week. The agency ordinance would then take effect 30 days after adoption. The agency ordinance must be effective before the agency structure can formally exist. The Board can appoint an agency Director upon the effective date of the agency ordinance. Should the Board wish to direct County Counsel to prepare an ordinance to create the agency, that work could be completed within 30 to 60 days of the Board's direction to do so.

Strategic/operational steps related to implementation of an agency

If an agency is created, several steps should be taken to reduce risks, establish safeguards, and build trust and reduce fear. As some stakeholders put it, "we love the concept; the devil is in the details of its execution."

Establish ongoing stakeholder engagement process: "We want a voice." To be successful and responsive to the needs of individuals and populations, the agency should establish mechanisms to ensure ongoing stakeholder engagement, including those representing a broad set of perspectives and issues. Clients/consumers/patients and their families, community advocates, private providers and service agencies, organized labor, the faith-based community, and experts/leaders in the field should be actively included. The forum would have several goals:

- Ensure community participation and input into ongoing planning and decision-making processes, including the prioritization of integration initiatives in a data-driven and evidence-based manner.
- Provide feedback on the impact of those initiatives, intended or otherwise.
- Create metrics that offer early indications of success or problems and review them on a periodic basis. Additional discussion of the importance of these indicators is included below.
- Establish a forum to express concerns, help to resolve disputes, learn from one another and begin to build trust among groups not accustomed to working together.

The agency should actively seek the involvement of stakeholders with particular insight into the needs of disadvantaged, underserved, and vulnerable populations to provide critical input on areas of unmet need, how program design will likely affect specific groups, and to serve as early warnings for adverse or unintended consequences of an initiative. This will be a critical element in ensuring the agency is successful in its role of reducing health disparities and promoting access and parity across populations and services. While stakeholder engagement could take many forms and focus on a variety of topics, several individuals within the population health community requested a venue dedicated to review of population health issues as one means of ensuring proper attention is paid to this critical public health realm. One suggestion was for a "Community Prevention and Population Health Task Force" that would report on fiscal, operational, and policy issues, delivering reports directly to the Board.

Stakeholders expressed concern as to how the stakeholder process would be set up, fearing a "superficial, check-the-box, stakeholder process." As one step, some stakeholders expressed a preference for having an external facilitator help guide discussion at these fora. Others specifically requested that the stakeholder process adopts a practice of not reimbursing individuals for their time, fearing it would "distort the motivations for their continued involvement and create an incentive to continuously add to the size and number of groups without attention to the actual benefit of these groups." While stakeholder input is critical, careful attention will have to be paid to the representation and membership of the group(s) formed. In soliciting input for this report, suggestions were made to include certain individuals, categories of individuals, or groups that, if all were accommodated, would total more than sixty people. While this size of group may be helpful as a way to support general input and communication, it may be less well-suited for in-depth discussions of issues and priorities.

Establish and clearly communicate an intentional set of initial priorities: The work of integration should begin immediately, rather than focusing staff time and energy on agency structure or investigating administrative efficiencies; the latter will evolve and clarify over time. Early and transparent goal-setting will help to center people's attention on initiatives that will yield concrete benefits for LA County residents and will help to avoid the risk that "thinking about the agency" will create a shared enemy that distracts attention from the true goal.

Regularly report on agency progress, including indicators related to agency impact: Many stakeholders were open about their anxiety of what the agency could mean and asked "What will you do to guarantee me that these things I fear won't happen?" As discussed in the section on Risks section above, these fears covered a broad range of topics, including notably continuity of existing services, service levels, and scope of county activities; preservation of funding streams, particularly MHSA and county general fund; additional bureaucracy with effect on contracting, HR, claims, and procurement processes; a loss of direct communication between the Departments and the Board; and the medicalization of community mental health with loss of critical recovery-centered services, among others.

It is necessary but not sufficient for County and agency leadership to make clear and repeated reassurances that they will work to make sure such fears will not become a reality. Agency and Departmental leadership should also be expected to report publicly, on a regular basis, on the opportunities being pursued and whether or not risks are being appropriately prevented. Carefully developed and transparently tracked indicators or metrics can also be critical in alleviating anxiety, building trust, and establishing a foundation for interactions that can focus on the work of integration. Such indicators would help to highlight whether or not services and operational functions are improving, but also could provide early warnings of adverse consequences of the agency's impact. Metrics will not cover all topics but should be broadly reflective of a variety of domains and functions. With respect to the development of these indicators, the following should be kept in mind:

- Metrics should cover a diverse array of activities, reflecting the full breadth of departmental scope. This should include measures that highlight population health, physical health, and mental health services; policy/regulatory

functions; community-based interventions; direct clinical services; and administrative practices. Each Department should independently validate that metrics are appropriately reflective of their scope and priorities.

- Metrics should focus on outcomes that are of direct importance to clients/patients such as access, customer experience, care quality, health outcomes, as well as administrative processes required to get the work done.
- Metrics should highlight how effectively individuals in specific populations (e.g., underserved or underpenetrated ethnic groups, vulnerable populations) and geographies are able to access and/or be connected to services and health outcomes among these groups. This is critical to reducing health disparities and provides an objective way to judge the appropriateness of resource allocation.
- Measures that are not directly related to public-facing services can also be helpful if they are designed to provide important information on the administrative and operational health of the agency. Covered areas could include staff satisfaction, HR efficiency, (e.g., time to fill an item), finance functions (e.g., time to process payment), and contracting/procurement functions.
- Measures of the financial impact of agency changes are critical in reassuring the community and building trust. This includes showing trends in and uses of different revenue streams and budget appropriations. It should also include estimated cost savings from administrative efficiencies, including ways of tracking the beneficiaries of these additional funds and how these savings were re-invested in services.

Indicator reports, when routinely measured and publically reported in a clear way, can serve as a powerful way of ensuring accountability and transparency. The development of these indicators will take time and could benefit from the involvement of external experts who can be neutral arbiters of what measures would be appropriate reflections of the agency's possible impact. The role of these external perspectives should not be limited to only metric development. Their continued involvement in the review and interpretation of data and review or audit of external publications would enhance accountability and build public trust.

It would obviously not be appropriate to attribute all change, either positive or negative, to the impact of the agency. The agency would not be implemented in a vacuum; the work of Departments and external factors would continue to influence these indicators. This fact should be taken into account both when designing the measures and also when interpreting the results. Reports should allow for qualitative interpretations of data, sharing a broader context and explanation of what is seen in the numbers.

Develop and publish clear, concise data on Departmental budgets, appropriation, revenue sources, and uses: The issue of clarity into financial data is related to the above discussion of indicators, but deserves specific attention. The single most common concern raised across stakeholder groups was that Department budgets, particularly those of DMH and DPH, would be cut over time in order to divert resources to other purposes, particularly within DHS. As discussed in the Risks section above, the very structure of the agency makes it impossible for funds to be moved between Departments without Board approval. Still, stakeholders need continuous confirmation that this is actually not happening and, at a more nuanced level, evidence that more subtle means of manipulating budgets is not taking place.

The County budget process and its communications are dense, filled with technical jargon, and are difficult to understand by those not constantly immersed in the subject. Effectively alleviating stakeholder concerns that the agency will lead to cannibalization of Department budgets will depend on clear and transparent budget communications. Finance staff working with public communications experts should develop simple charts showing where key funding streams are being spent, including notably MHSA funds and County general fund dollars. The data behind these charts should also be made available to the public.

Clearly communicate changes with the public: External partners, community agencies, and service providers need to know the changes that are being made to Departmental structure and programs so they know where to go to get the information

they need. Stakeholders expressed concern that the agency would lead to changes in administrative functions or shifts in roles and responsibilities within the County over time and that they would be left "out of the loop and wondering where to go." The need for clear and frequent communications cannot be overstated and, as several individuals reminded, is not a particular strength of the County. Some suggested that those within the Departments with notable expertise and experience in managing public communications could share best practices across the agency.

Create opportunities to build relationships and trust among staff: While the proposed structure is not a merger, the creation of an agency would promote opportunities to integrate the cultures of the Departments in a way that shares best practices and increases respect, trust, and understanding of each Department's strengths. One stakeholder described needing to work to increase "the cultural competency not just for the individuals we serve, but also in regards to the staff within our Departments." The impact of culture on the integration of the three departments cannot be taken lightly. It is possible to create an agency that works effectively together across its distinct parts to improve services to clients/consumers/patients, but doing so will require significant work and should be a major priority. The importance of this process was strongly emphasized by internal and external stakeholder alike.

To achieve this, front-line staff should be actively engaged in a discussion of agency mission and priorities and must be given opportunities to build relationships over time through real work. Where prior integration activities have succeeded in a sustainable and deep manner, success was attributed to a sense of shared mission and goals and a commitment from those involved working as a team to overcome operational barriers. Some individuals however cautioned that these interactions should not be forced: "Cultures need to simmer and not be immersed instantly; cultural understanding and relationships take time." Trust is built over time through clear and open communications, transparency, establishment and tracking of performance goals, and through clear and open communication. The agency should be sure to invest in the resources needed to enable people to do their work and promote a culture built on labor-management partnership.

Conclusion

This document has attempted to outline both the opportunities and risks of an agency model, including the potential ways in which these risks can be addressed through design of the agency structure and specific implementation steps. The hope is that through this report, and the extensive internal and external stakeholder process that helped inform it, LA County leadership is well positioned to determine the best path for the County's three health-related Departments so that it may maximize opportunities for innovation and integration and ultimately improve the health and lives of all LA County residents.

If the Board of Supervisors chooses to proceed with creating an agency, the following is a set of recommended actions that may be taken:

- Direct County Counsel to prepare an ordinance to create the agency, reporting back to the Board with the ordinance language in within 30-60 days.
- Appoint an agency director, either interim or permanent at the Board's discretion, upon the effective date of the agency ordinance.[35]
- Direct the agency director, in collaboration with Department heads and external stakeholders as relevant, to develop and report back to the Board on
    - An agency mission and vision statement
    - A mechanism for ensuring meaningful ongoing dialog with external stakeholders
    - A set of indicators to be routinely tracked and reported to the Board as a means of gauging the agency's effectiveness and impact, including potential adverse consequences; specific attention should be paid to indicators that can reflect sources and uses of existing Department funding streams
    - Plan with respect to shifts of units from the Department to the agency level, including those units noted in "Proposed Structure" as benefiting from prompt reassignment to the agency
    - Plan with respect to assignment of individuals to an agency-level role (including dual agency/department roles), including the anticipated costs of these positions, if any, and the proposed mechanism for funding such costs if they exist.
    - Initial prioritization of integration initiatives
- Establish a regular (e.g., quarterly) public hearing before the Board of Supervisors for a minimum of 18 months in which the agency director and each of the Department heads would report on agency priorities and activities, including whether opportunities and risks are being realized. Community stakeholders should also be encouraged to attend and speak about the impact of the agency to date.

Over the longer-term, the agency director should further investigate, as needed, or pursue specific opportunities to enhance integration between the three Departments. This should include particular attention to service integration activities as well as opportunities for maximizing available revenue/financing streams, ensuring optimal levels of IT integration, and maximizing use of space for both clinical and administrative purposes.

[35] As noted in "Implementation Steps" section above, the agency ordinance must have two readings at a Board meeting before being adopted and would take effect 30 days after adoption.

Appendix I: Board Motion on Health Integration

AGN. NO._____

MOTION BY MAYOR MICHAEL D. ANTONOVICH JANUARY 13, 2015

AMENDMENT TO AGENDA ITEM #2

Historically, the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) operated as a single department within our County. In response to a variety of factors and the need to establish distinct identities, the Board separated the three functions into three separate departments. While the decisions to separate the functions into three departments were appropriate at the time, evolving trends in health care delivery, policy, and reimbursement have changed. In the present and expected future health care environment, it would be better for the County to operate a single unified health ~~department~~ **agency** that encompasses all aspects of population and personal health.

By integrating DHS, DMH, and DPH, the County will be better positioned to provide high quality, comprehensive health-related services and programs to County residents. Additionally, a single combined health ~~department~~ **agency** would be best positioned organizationally to break down the bureaucratic barriers facing the County's patients, identify synergies between programs, streamline operations, optimize finances and align incentives so that all County staff work toward the goal of providing high-quality, patient-centered, cost-effective health services across the full continuum of

MOTION

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health services. Additionally, consolidating the three departments should result in budgetary savings by sharing capital or administrative expenses, while yielding tangible benefits for patients in terms of service delivery enhancements.

Finally, it makes sense to also consolidate the environmental toxicology bureau functions currently performed by the Department of Agricultural Commissioner/Weights and Measures within the new consolidated health services ~~department~~ **agency**.

I, THEREFORE, MOVE that the Board of Supervisors:

1. Approve in concept the consolidation of DHS, DPH, and DMH into a single integrated ~~department~~ **agency**, including the assumption of the environmental toxicology bureau functions currently performed by the Agricultural Commissioner; and
2. Instruct the Chief Executive Officer, County Counsel and the Department of Human Resources, in conjunction with the Department**s** of Health Services, **Mental Health, Public Health, and Agricultural Commissioner/Weights and Measures** to report back within 60 days with a proposed structure ~~to~~ **that might** accomplish ~~the~~ **such a** consolidation, as well as ~~proposed~~ **possible** implementation steps, ~~and a~~ time frame for achievement of the ~~consolidation~~ **agency, and the benefits as well as any drawbacks to this action. In addition the CEO should establish a stakeholder/public participation process to ensure that their input is considered in the report.**

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Appendix II: History of DHS, DMH, and DPH organizational structure

The Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) were initially created as separate entities. In 1972, DMH and DPH were merged with hospitals (and veterinary services) to create a single Department of Health Services in response to the findings of the Board-established Health Services Planning Committee that found having multiple departments resulted in service fragmentation, duplication of effort, and difficulties in coordinating health programs. Many stakeholders have also pointed out that the move to combine mental and physical health also stemmed from the availability of new funding in the mental health arena and the desire from some to use that funding more flexibly to address gaps in hospital budgets.

The next six tumultuous years were characterized by unstable leadership in mental health; competing geographic program structures; de-prioritization of mental health services that were overshadowed by hospital issues; inadequate attention to the ongoing de-institutionalization of mental health care that was a major theme at the time; and diversion of mental health funding to address physical health service needs. In response, the Board adopted an ordinance in 1978 establishing an independent DMH which held responsibility for all mental health services functions except for inpatient and emergency psychiatric treatment which continued to be provided at DHS facilities with DMH responsible for the cost of this DHS-provided care. In addition to hospitals, DHS retained duties associated with public health and the County Health Officer; alcohol and drug programs; and the County veterinarian services. At that time, all physical health clinics were a function of the DHS division of public health. In the early 1990s ambulatory clinics, except twelve public health clinics, were aligned with the hospital facilities and became today's Comprehensive Health Centers and Health Centers.

That structure remained until 2006 when the Board created a separate Department of Public Health. While a variety of factors influenced the Board's decision, five primary stated concerns supported the need for separate a Department:[36] 1) Anticipated budget reductions for public health activities as a result of projected deficits in DHS hospitals and clinics, a tension amplified by public health being a general fund unit whereas health services operates as an independent enterprise fund.[37] 2) Different missions -- DHS being that of care to low income individuals while DPH has a broader population mission -- and the risk that DHS problems and larger size would lead to the de-prioritization of public health activities; 3) Perceived greater ability of public health to advocate for its interests before the Board and greater ability for DHS' director to focus attention on "critical indigent health issues and long-term funding problems"; 4) Anticipated growth in size and scope of public health activities and roles; and 5) The need for an experienced public health physician leader to act as the County's Public Health Officer. At that time, the possibility of DHS hospitals shifting to an alternative governance structure under a Health Authority model also appears to be a factor in the decision. While recommending the split, Mr. David Janssen, the County CAO at the time, wrote of the need to "continue to integrate prevention activities into the personal health care system" a fact which would require a "strong agreement" between the two departments to guide such activities. In expressing concern with the split, DHS Director Dr. Thomas Garthwaite, expressed concern that continued collaboration would suffer, depending entirely on the "will of leadership" and "not assured or promoted by the structure."

This separation resulted in hospitals and ambulatory clinics (except those specific to public health services only) and some other services, such as managed care, juvenile court health and emergency medical services, making up DHS. By ordinance, DPH included public health services, AIDS programs, alcohol and drugs programs (SAPC) and children's services. Over the subsequent three years, the County briefly considered moving select functions, such as Alcohol and Drug Program Administration, Children's Medical Services, the Office of Women's Health, and Emergency Medical Services but opted to retain the existing reporting relationships. This general division of departmental responsibilities remains in place today.

[36] Based on a memo from David Janssen, Chief Administrative Officer, to the Board on June 9, 2005.
[37] A government's general fund is a pool of cash raised from taxes and can be spent wherever the government needs it. In contrast, an enterprise fund can only be spent on a specific purpose with most of the funding coming from revenue related to the fund's mission.

Appendix III: Structure of health-related services in other counties

LA County is the largest county in the United States with a population of nearly 10 million residents. It is also one of the nation's most ethnically and socio-economically diverse counties. While there is no county that can be put forward as a perfect comparison to LA County, it is still helpful to understand how other large counties structure their health departments, particularly counties within California given that the way State's structure state vs. local roles and responsibilities differs by state, and also among very large counties outside of California, which are helpful comparisons due to their size and diversity.

For this report, we reviewed the structure of county health-related services in the largest California counties and also the ten largest counties outside of California. A brief summary of the structure of these comparison counties is provided below.

Fifteen largest Counties in California:

County	Population[38]	Sq. Miles[39]	Organizational model[40]			Brief description
			Fully integrated	Partially integrated	Separate	
Los Angeles	9,818,605	4,058			✓	Separate departments of Health Services, Mental Health and Public Health
San Diego	3,095,313	4,207	✓			Mental health, public health and substance abuse, along with social services, report to the County's Health and Human Services Agency. There are no public hospitals or clinics in San Diego County.
Orange	3,010,232	791	✓			Mental health, public health, and substance abuse report to the County's Health Care Agency. There are no public hospitals or clinics in Orange County.
Riverside	2,189,641	7206			✓	Separate mental health, public health and physical health departments.
San Bernardino	2,035,210	20,057			✓	Separate mental health, public health and physical health departments.
Santa Clara	1,781,642	1,290	✓			All components (hospitals, clinics, public health, mental health, substance abuse) report to Santa Clara County Health and Hospitals System.

[38] U.S. Census Bureau, Census 2010

[39] U.S. Census Bureau, Census 2010

[40] Refers to the reporting relationship for hospital, physical health clinics, public health, mental health, and alcohol and drugs to County governance when such functions exist at the County level. Not all counties in California operate public hospitals or clinics. For the counties outside of California, some states delegate responsibilities for public and mental health to the state or city, rather than the county. "Fully integrated" refers to a structure in which the health-related functions (those that exist) report to a single individual who is responsible for health. This may indicate either an agency structure or a merged department structure. "Partially integrated" refers to a structure in which some, but not all, of the health-related functions report to a single individual responsible for health. "Separated" means that each health-related function reports separately to County leadership.

County	Population[38]	Sq. Miles[39]	Organizational model[40]			Brief description
Alameda	1,510,271	739		✓		Mental health, public health, and substance abuse, among other functions, report to the County's Health Care Services Agency. Public hospitals and clinics report to the Alameda Health System, a health authority.
Sacramento	1,418,788	965	✓			Mental health, public health, substance abuse, and clinics, along with social services, report to the County's Health and Human Services Agency. There are no public hospitals in Sacramento County.
Contra Costa	1,049,025	716	✓			Mental health, alcohol and drugs, public health, hospitals, and clinics, as well as other functions, report to Contra Costa Health Services.
Fresno	930,450	5,958			✓	Separate mental health and public health departments. Substance abuse is contracted out by both public health and mental health. There are no public hospitals or clinics in Fresno County.
Kern	839,631	8,132			✓	Separate mental health, public health and physical health departments. In the process of creating a health authority for hospitals and clinics.
Ventura	823,318	1,843	✓			Mental health, alcohol and drugs, public health, hospitals, and clinics, as well as other functions, report to Ventura County Health Care Agency.
San Francisco	805,235	47	✓			Mental health, alcohol and drugs, public health, hospitals, and clinics, as well as other functions, report to San Francisco Department of Public Health.
San Mateo	718,451	448	✓			Mental health, alcohol and drugs, public health, hospitals, and clinics, as well as other functions, report to the County of San Mateo Health System.
San Joaquin	685,306	1,391		✓		Public health, mental health, and substance abuse report to San Joaquin Health Care Services Agency. The public hospital and clinics report separately to the County Board of Supervisors.

Ten largest US Counties outside of California

County	Population[41]	Square Miles[42]	Organizational model[43]			Brief description
			Fully integrated	Partially integrated	Separate	
Cook County, IL	5,194,675	945		✓		Hospitals, clinics, jail services and suburban public health (134 cities) are integrated under the Cook County Health and Hospitals System. Chicago has a separate public health department. Mental health is a state / city function in IL.
Harris County, TX	4,092,459	1,703			✓	County public hospitals and clinics (Harris County Health System) report separately than public health. Mental health is a state function in TX.
Maricopa County, AZ	3,817,117	9,200			✓	Maricopa Integrated Health System is a health authority with hospitals & clinics. The county runs a separate Department of Public Health. Mental health is a state function in AZ.
Miami-Dade County, FL	2,496,435	1,898		✓		Hospitals, clinics, mental health, and substance abuse are integrated under the Jackson Health System. Public health is a state function in FL.
Kings County, NY	2,504,700	71		✓		Health-related services in the counties that comprise New York City are managed by the City. NY Health and Hospital's Corporation operates NYC's public hospitals and clinics. Mental health, public health, and substance abuse are integrated within the NY City Department of Health and Mental Hygiene.
Dallas County, TX	2,368,139	871			✓	County public hospitals and clinics report separately (to Parkland Health System) than public health. Mental health is a state function in TX.
Queens County, NY	2,230,722	109		✓		Same as Kings County, NY, above.
Clark County, NV	1,951,269	7,891			✓	County public hospitals and clinics report separately than public health. Mental health is a state function in NV.
King County, WA	1,931,262	2,116			✓	County public hospitals and clinics, mental health, and public health report separately.
Tarrant County, TX	1,809,034	864			✓	County public hospitals and clinics report separately than public health. Mental health is a state function in TX.

[41] U.S. Census Bureau, Census 2010
[42] U.S. Census Bureau, Census 2010
[43] See explanations of organizational model in footnotes to California table above.

In compiling this report, a number of leaders in California county health departments/agencies were interviewed about their county's structure for health functions and the impact of this structure on the ability to integrate care and maximize benefits to county residents. A few themes emerged from these conversations; these themes, and representative quotations, are included below.

An agency structure is necessary but not sufficient for achieving integration goals: Those within an agency structure were almost unanimously supportive of it, even when speaking with those over specific areas, such as mental health, public health, and clinics. In some cases, individuals in counties that separated their health-related departments had an interest in the agency model. Interestingly, several people commented on how separating health functions into different departments reflected outdated practices. At the same time, those interviewed offered words of caution as to how completely or quickly benefits could be achieved.

- "If you were to design a new health system from scratch in 2015, there's no chance anyone would design it as three separate departments. That may have been necessary in the past when people didn't recognize mental illness or appreciate the value of population health activities. But doing it today is a recipe for non-action."
- "People are not their diagnoses. [LA County] has institutionalized its fragmentation."
- "Technically, you could integrate without an agency. But in practice, it will never happen. All of the forces, including financing very slowly, are moving toward integration. If you aren't organizationally structured to do it, you won't make progress at the rate you should."
- "It's insane that we have allowed ourselves to create a system where these services are separated. People are whole people, not separate body parts and organ systems."
- "Of course they should be together. But hopefully no one is fooling themselves that it will be a panacea. No real progress of any size and scope will be made without it, but it won't solve everything either. Organizational structure is a prerequisite; it's necessary but not sufficient."
- "The structure can help the County make progress on priorities. That said, everything can't be a priority all at the same time. You have to make tough choices about what to push forward."
- "Our system is unfortunately very fragmented and does not serve the population well. If an agency could help with that, I'd be interested."
- "In light of the ACA, the whole country is looking at how to better integrate health delivery systems."

Considerations of how LA County's size should impact decisions on agency structure: Many people commented on LA County's size and its uniqueness and complexity as a result. Despite these comments, people did not have firm opinions as to what this size should mean with respect to organizational structure.

- "I'm not sure if it's the biggest reason to do the agency or it's the biggest reason not to. LA County is huge: the size of the agency would be immense, with all of the problems that can bring in a government. But at the same time, LA County is huge: there's no way progress can be made at scale without hardwiring it into the structure of the organization."
- "We [small county] can integrate care without reorganizing ourselves because we all know everyone in the county by name. LA can't do that. Maybe that's a reason why the agency is needed there."

Importance of maintaining vigilance regarding budgets, spectrum of services, and service levels: Several county leaders agreed with the Board's proposal of an agency rather than a merged structure, because of the impact on maintaining separate budget appropriations and the greater confidence that separate departments would be able to maintain existing services. Two individuals, however, felt the budget separation, while necessary, would detract from the benefit of the agency.

- "Given LA's sordid history, there's no way this should be pursued unless there are firm safeguards around separate department budgets. It would be a shame to see happen again what happened to public health in the 2000s."
- "The advantages of an agency are obvious but the difficulties are practical; can you ensure clients who the system works for now can still get the care they need."
- "The challenge will be making sure public health concerns don't get crushed under the weight of clinical delivery system crises. It can be done, but you have to be intentional."
- "It works for us because we have an agency director who cares deeply and is knowledgeable about all of the areas."
- "I imagine you have to make sure there's a steel firewall between the budgets, but really it is very limiting. You can't maximize available federal and state reimbursement unless you allow yourself the ability to move funds around between units."

Appendix IV: Brief Overview of Process for Developing this Response to the Board

In preparing to respond to the Board's January 13, 2015 motion, a concerted effort was made to obtain the input from a broad range of internal and external stakeholders. This included outreach to those external entities, including Commissions, advocacy groups, non-profits, and other groups identified by the Departments, with opportunity for presentation and discussion of the Board motion. Over 35 stakeholder meetings were held. A full list of these stakeholders is provided below. Additionally, labor unions with members in one of the affected Departments were briefed on the issue and offered an opportunity to raise questions or concerns. Each labor union then established their own process for additional engagement with their membership. Finally, executives in California larger counties outside of Los Angeles were also interviewed, as were individuals with knowledge of the structure of major US Counties outside of California.

External Stakeholders	
AFL-CIO	Los Angeles Housing + Community Investment Department
AFSCME	Maternal & Child Health Access
AIDS Project Los Angeles	Mental Health Advocacy/Legal Advocates
Alzheimer's Association	Mental Health Consortium
Ambulatory Care Network Advisory Board	MHS Oversight & Accountability Commission
American Heart Association	National Alliance on Mental Illness
American Indian Community Council	National Alliance on Mental Illness Urban LA
American Lung Association	Neighborhood Legal Services of Los Angeles County
Antelope Valley Partners for Health	ONEgeneration
Asian Client Coalition	Operating Engineers and Building Trades
Asian Pacific Policy & Planning Council	Pacific Clinics
Association Community Human Services Agency	Prevention Institute
Black Los Angeles County Client Coalition	Project Return Peer Support Network
Blue Shield California Foundation	Public Health Alliance of Southern California
California Alliance of Information and	Roybal Institute/USC
Referral Services	Service Area Advisory Committee Chairs
California Association of Alcohol and Drug	(plus 8 Service Areas)
Program Executives	SEIU Local 721
California Center for Public Health Advocacy	Southern California Association of Non-Profit Housing
California Community Foundation	Southern California Public Health Association
California Endowment	System Leadership Team (SLT)
Children's Systems of Care / Transitional Age Youth	Teamsters Local 911
Committee on Interns and Residents	The Wall Las Memorias Project
Community Clinic Association	Union of American Physicians and Dentists
Community Health Councils	UCLA, Fielding School of Public Health
Community Partners in Care	Under-Represented Ethnic Population
Cooperation for Supportive Housing	UniHealth Foundation
DMH Faith-Based Advocacy Council	U.S. Department of Health and Human Services Promotoras
Empowerment Congress	Initiative Steering Committee
Greater LA Black Infant Health Consortium	USC, Environmental HS Department
Hospital Association of Southern California	Western Center on Law & Poverty
Housing Trust Advisory Group	
Housing Works	**Commissions**
Insure the Uninsured Project	Commission for Children and Families
International Union of Operating Engineers	Commission on Alcohol and Other Drugs
LA Care Health Plan	Commission on HIV
LA Homeless Service Authority	Commission on the Status of Women
Latino Client Coalition	Hospital and Health Delivery Commission
Local 1083, 36, 2712, 3511 & 1921	Mental Health Commission
Long Beach Public Health	Public Health Commission
Los Angeles County Client Coalition	

Input was also obtained from County staff through a number of different forums. This included the development of seventeen workgroups (see list of workgroups below) focused on a wide set of clinical, programmatic, and administrative topics, who met to discuss the responses to the Board motion from the vantage point of their content expertise.

Interdepartmental workgroups
Facilities / Space Planning
Finance / Revenue Generation
Housing
Human Resources
IT and Data
Managed Care Contracting
Pharmacy/340B Reimbursement
Purchasing/Contracting
Service Integration: Ancillary Services
Service Integration: Care for Individuals Requiring Physical, Behavioral and Public Health Services
Service Integration: Community-based Interventions, Population Health, and Personal Care
Service Integration: Contracted Clinical Services
Service Integration: Foster Children and Transitional Age Youth
Service Integration: HIV
Service Integration: Re-entry Populations
Service Integration: Response to Public Health Threats
Service Integration: Streaming Access to Care

An initial draft report was prepared by staff from CEO and County Counsel. Leadership from the County CEO (including Employee Relations, Compensation, Budget/Finance, etc.), County Counsel, Department of Human Resources, DPH, DHS, and DMH were each asked to review and directly edit the initial draft for both factual accuracy and also to ensure the full set of perspectives and points were reflected. All efforts were made to ensure their input was fully taken into account. Approximately 95% of direct edits obtained were incorporated into the document. In certain cases, direct edits were not accepted because of factual inaccuracies, duplication with other text, distortion of points raised by stakeholders, etc. These situations were communicated to the Departments. In a few cases, requests for certain aspects of the text to be deleted were not accommodated because it was felt such deletions would remove key points raised by different stakeholders. In these situations, Departments were offered a chance to edit the text to highlight a counter-point or alternative view, edits which were incorporated into the document. The specific places in which Departments requested deletions that were not accommodated include:

- DMH and DPH requested the idea of Department staff holding dual-roles within the agency be deleted.
- DMH preferred that data/analytic and contracting/purchasing agency roles be deleted.
- DPH requested that the document list the disadvantages of an agency which were articulated by stakeholders without addressing each point, explaining why the risk would be unlikely/unable to occur, or how the risks could be mitigated.
- DPH requested deletion of the reference to how the clinical environments of DHS and DMH could be rich environments to study, test, and implement programs.
- DPH requested deletion of the statement describing the CEO's current position of not supporting new investment into the agency.

Quotations included in this report are actual statements made during the stakeholder process; in certain cases, they were edited for the sake of brevity. Quotes are included from both internal County staff and external stakeholders and are only included if they represented the general perspective raised by more than one individual. Identifying information is

intentionally withheld, even in those cases where the speaker may have been willing to be identified since not all individuals were willing to be quoted and since such information would not add to the quality of the narrative.

Following submission of this draft report, the CEO will open up a 45-day public comment period. Both written and oral comments will be accepted, the latter collected from one of the planned public convenings. The date and location of these convenings will be posted on the Health Integration website: http://priorities.lacounty.gov/health/. Written and oral input is welcome and encouraged in a sincere effort to improve the quality of the final report. All written comments will be included as appendix material in the final report unless specific requests are made to keep them confidential.